Catholic Family Services of Durham
Services à la famille catholiques de Durham

707 Simcoe Street South, Oshawa, ON L1H 4K5
Phone: (905) 725-3513
Fax: (905) 725-8377

250 Bayly Street West, Ajax, ON L1S 3V4
Phone: (905) 428-1984
Fax: (905) 428-6135

PARENTAL CONSENT FOR COUNSELLING CHILDREN UNDER 12 YEARS OF AGE

(Please put ✓ in ❒ if applicable)

☐ In agreement to the conditions of service, I/We hereby give consent for my/our child(ren) to receive counselling at **Catholic Family Services of Durham/ Services à la famille catholiques de Durham.**

☐ I/We understand that in giving consent for counselling, I am consenting to the therapeutic intervention assessed as clinically indicated by the therapist and could include (but is not limited to): individual work, group work, and/or family work. If I/We have questions about the therapeutic approach I/We can discuss them with the therapist.

☐ I/We understand that in separation/divorce when the custody rights of the child(ren) are shared, consent from both parents is preferred for my/our child(ren) to receive counselling at **Catholic Family Services of Durham/ Services à la famille catholiques de Durham.**

I/We have:

☐ permanent sole or
☐ temporary sole or
☐ permanent joint or
☐ temporary joint custody rights of the child(ren); and consent from both parents is:
❒ needed ❒ not needed.
☐ other _____

The name(s) and date(s) of birth of the child(ren) is(are) listed as below:

_____
Child Name Date of Birth *(month/day/year)*

_____
Child Name Date of Birth *(month/day/year)*

_____ _____
Parent's Signature Date of Signature *(month/day/year)* Parent printed name and contact number

_____ _____
3rd Party Witness' Signature Date of Signature *(month/day/year)* Witness printed name & contact number

_____ _____
Parent's Signature Date of Signature*(month/day/year)* Parent Printed name and contact number

_____ _____
3rd Party Witness' Signature Date of Signature *(month/day/year)* Witness printed name & contact number