CT STATE COMMUNITY COLLEGE

185 MAIN STREET
NEW BRITAIN, CT 06051
CTSTATE.EDU

Mental Health and Wellness

PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

No part of this form may be edited and all fields mut be completed to be valid.

Client Name (Minor): _____
Date of Birth: _____
Parent/Legal Guardian Name: _____
Relationship to Minor: _____
Address: _____
Phone Number: _____
Email Address: _____

PURPOSE

This form grants permission for the above-named minor to receive mental health services at CT State Community College from a licensed mental health professional.
Mental Health Services include:

- Psychological assessments and evaluations
- Individual or group counseling sessions
- Crisis intervention and safety planning
- Referrals to external providers and resources when clinically appropriate

CONSENT

I, the undersigned, am the legal parent or guardian of the minor named above. I hereby give my voluntary consent for the minor to participate in mental health services at CT State Community College.
I understand that:

- Mental health treatment records are protected by the Family Educational Rights and Privacy Act (FERPA) and applicable state and federal confidentiality laws.
- All communication with the parent/guardian will be at the discretion of the Wellness Counselor and information will be shared in the event of imminent safety concerns.
- I authorize the counseling staff to provide treatment until my student reaches the age of 18, unless I revoke this consent in writing earlier.

EMERGENCY CONTACT (complete only if different contact then above)
Name: _____
Relationship: _____
Phone Number: _____

I certify that I have legal authority to consent to treatment for the above-named minor.

Parent/Guardian Signature:

Date: _____