

COUNSELOR OR MEDICAL AUTHORIZATION

**This must be completed by EACH participant.
Please keep a copy for your records.**

PARTICIPANT NAME (PRINT): _____

My child (check one)...

is *is not*

...currently under the care of the following physician, psychiatrist, psychologist, counselor or other medical or counseling professional. The name, address and telephone number of each such professional is listed below, and I have fully described the Discovery! Teen program to such professional and obtained his/her agreement, authorization and consent for my child to participate in the program.

To be completed by professional (if applicable):

Professional name (print): _____

Professional address: _____

Professional telephone no.: _____

Nature of care: _____

I HEREBY AUTHORIZE THE PARTICIPANT WHOSE NAME APPEARS ABOVE TO PARTICIPATE IN THE Discovery! Teen PROGRAM.

(Signature)

(Date)

(Attach additional pages for other professionals if necessary)

If my child is not currently under the care of a physician, psychiatrist, psychologist, counselor or other medical or counseling professional, but has within the past five years received psychological counseling, therapy, or any similar treatment, I agree to fully disclose the nature and extent of such treatment to the Discovery! Teen Program Provider and obtain written permission from any such professional if requested.

Nature of care (to be completed by parent/guardian if any professional care within the past five years): _____

I understand the Discovery! Teen program is not intended as a substitute for medical care or traditional psychiatric or psychological counseling. I have not enrolled my teen in the Program as a means of treating or managing physical, alcohol, drug or emotionally related problems.

PARENT/LEGAL GUARDIAN:

Sign Here: _____ Date: _____

Print Name: _____