Consent for Treatment of Minors

Name of Client:

Date of Birth:

This is to certify that I give permission to Blue Sky Ranch Therapy Services and Diane Bidwell, LSCSW and Camber White, EAGALA trained to treat my child.

This treatment includes individual therapy and/or individual therapy along with equine assisted therapy.

Parent or Guardian _____Date:

Street Address _____

City/State/Zip_____

Phone_____

Witness/Title_____