Counseling Consent Form

Department of Counseling and Higher Education
Eastern Illinois University

Student:_____

Parent/Guardian:_____

Phone #:_____

Counselor:_____

School:_____

My signature below indicates that I understand that the counseling service is designed to help my child as he or she participates in the counseling experiences. I further understand that the counseling services will be provided by a graduate student (from Eastern Illinois University) under competent supervision of _____(Instructor's name) and that all information on my child will be kept confidential.

Please sign and date below.

Parent or Guardian's Signature:_____

Student's Signature:_____

Date:_____

Counselor's Signature:_____