STUDENT HEALTH CENTER
LAMAR UNIVERSITY

## CONSENT FOR COUNSELING/MENTAL HEALTH TREATMENT OF A MINOR

**(Consent for treatment of a student under 18 years of age)**

If you are a student under the age of 18 seeking Mental Health Counseling Services, Texas State Law *(Texas Family code, Section 32.004)** requires that a parent or guardian grant permission for treatment unless any of the following circumstances apply (please initial all that apply).

_____ I am on active duty in the armed forces.*

_____ I am at least 16 years old ***and*** reside apart from my parents/guardian ***and*** manage my own financial affairs regardless of the source of income.*

_____ I am thinking about suicide.*

_____ I have concerns about alcohol and/or drug addiction or dependency.*

_____ I have been sexually, physically, or emotionally abused.*

If any of the above sections have been initialed, then Counseling Services will be offered without parental/guardian consent.

If none of the above sections apply, we will need parental/guardian consent before continuing with Mental Health Services. This document will remain in effect until the student's 18th birthday. Please complete the bottom of this form and return it to the Student Health Center prior to scheduling the next counseling appointment.

## STUDENT:

I _____ (student) understand that under Texas State Law, parents/guardians have access to Counseling/Mental Health Records if requested or could talk with your Counselor whether parental consent is necessary or not. By signing below I acknowledge that:

- I have read and understand its contents, including the limits of confidentiality as stated above.
- The information I have provided is accurate.
- I am request counseling services from Lamar University Student Health Center.

_____ Date:_____
(Students signature)

## PARENT or GUARDIAN:

I_____ (parent/guardian) understand that under Texas State Law, parents/guardians have access to Counseling/Mental Health Records or could talk with a Counselor whether parental consent is necessary or not. By signing below I acknowledge and give consent that:

- I have read and understand the document contents, including the limits of confidentiality as stated above.
- I understand that my student/child has requested Counseling services at Lamar University Student Health Center.
- I understand that recommendations for treatment may include referrals to psychiatrists, medical professionals, medications or other resources and do give my permission for treatment.

_____ Date:_____
(Parent/Guardian signature)