Teach Oscail Counselling and Therapy Centre

Child/Young Person's Name (BLOCK CAPITALS):	
Age:	***Date of Birth:***
Name of Parent(s)/Guardian(s) (BLOCK CAPITALS):	
Relationship to Child/Young Person:	
Contact Address:	
Parent (s)/Guardian(s) Contact Telephone No:	
GP Name & Contact Details:	

Please give more detail on issue prompting Child/ Young Person to seek Counselling

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Is the Child/ Young person aware that this referral is been made on their behalf?

Yes □ No □

Parent Consent:

It is necessary to gain permission from the Parent/Person with Legal Parental Guardianship responsibility, for counselling to take place with a child/young person aged 18 and under. The person named in the box above must therefore hold Legal Parental/Guardianship responsibility. **It is our policy, where Parental/Guardianship responsibility is shared, that both parties consent to this request being made on behalf of the Child/Young person.**

Signed:____________________________________ **Date:** ____________________

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Signed:___________________________________ **Date:** __________________

(Adults with parental responsibility for the above named child/ young person)

Please Sign below if only one parent/guardian is responsible for child.

Disclaimer: I________________________ take full responsibility as sole guardian for (name of child) _____________________ to attend Therapy with Teach Oscail Family Resource Centre's. Counselling service.

Please return to: Teach Oscail FRC, 31 Church Street, Cavan.