GROUP COUNSELING CONSENT FORM

Department of Counseling and Student Development
Eastern Illinois University

Practicum/Internship Instructor: _____

Site of Counseling Services: _____

Site Address: _____

Site Supervisor: _____ Semester/Year: _____

I _____ hereby give permission for _____
(Parent/Guardian's name- PRINT) (Student/Clients' name- PRINT)

to participate in group counseling with _____.
(School Counseling Graduate Student's Name- PRINT)

The information shared in a counseling relationship is treated with the deepest respect. For the most part the information shared in a counseling session will not be repeated to anyone. We have an ethical responsibility to share some information. We are required by law to notify parents of any threats of suicide. We are also required to notify the proper authorities of child abuse, neglect and threats to harm others. We must also turn over records that are subpoenaed by a court of law. We hope that you understand our ethical and legal responsibility concerning these matters.

I understand that I may revoke this permission at any time.

_____
(School Counseling Graduate Student's Signature)

_____
(Student/Client's Signature)

Signature of Parent/Guardian: _____ Date:_____

Parent/Guardian Name (Please Print): _____

Address: _____
(Street) (City) (State) (Zip)

Telephone: _____