

Stepping Stones



Child & Adolescent Services

Serving Butler, Coffee, Covington & Crenshaw counties
A service of South Central Alabama Mental Health

PARENTAL CONSENT FOR SERVICES

I, _____ give permission for SCAMHC staff to
Parent Name

provide clinical services to my child, _____
Child's Name

at _____. I understand this authorization is
Name of School

voluntary and I may revoke this at any time by notifying SCAMHC staff verbally
or in writing. This form must be updated yearly.

Parent/Guardian Signature

Date

SCAMHC Staff Signature

Date