Preferred EAP®
How Healthier Happens

Consent for Treatment for Children

Age 13 or Younger (PA)
Age 15 or Younger (NJ)

We, the parents/guardians of (name of child) _____, consent for our child to receive counseling services from Preferred EAP.

By signing below - we both consent to treatment for our child.

Name of Parent/Guardian 1: _____

Signature of Parent/Guardian 1: _____Date: _____

Name of Parent/Guardian 2: _____

Signature of Parent/Guardian 2: _____Date: _____