MANITOBA BLUE CROSS®

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EMPLOYEE ASSISTANCE CENTRE CONSENT TO TREAT A MINOR

This form must be completed and returned to eapintake@mb.bluecross.ca before the first appointment.

Note that both parents/guardians must sign the form.

I agree to give the therapist noted below permission to begin treatment with my child/children, as indicated by my signature below:

Name of child client Age

Name of child client Age

Name of child client Age

Signature of parent(s)/guardian(s) Relationship to child Date

Signature of parent(s)/guardian(s) Relationship to child Date

Employee Assistance Centre Counsellor

Statement of Understanding: Limitations and Focus of Counselling for Minors

I understand there are limitations with the counselling services to which I am consenting for my child/children and I understand and agree as follows:

- I understand the primary focus of EAP counselling includes developing an understanding of the presenting concerns, undergoing short-term counselling, being referred for external services when necessary, and that services are clinical in nature and are not intended for purposes outside the counselling process itself (e.g. court proceedings, custody evaluations, legal proceedings, school requests for information or reports, other third party requests for information).
- I understand the counselling services provided to my child to which I am consenting are solely intended to provide assistance for my child and my child's familial and social relationships. As such, from time to time at the discretion of the counsellor, either or both parents may be involved in the counselling process – and at the counsellor's discretion, either parent may be informed of my child's progress in counselling, unless an existing court order specifies otherwise.
- I understand the EAP does not provide verbal or written review or assessment information to third parties and I further agree that written and/or verbal submissions of any kind pertaining to the services provided will not be requested by me or my legal representatives.
- Notwithstanding the above, I understand that limitations to confidentiality that govern counselling and treatment will continue to apply.

I, ______________________________ have read and understand this Statement of Understanding that outlines the
Name of Client
limitations and focus of counselling services to be provided to my children.

Signature of Parent or Guardian ______________________________ Date ________________

Signature of Parent or Guardian ______________________________ Date ________________

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