

PROFESSIONAL CONSULTING

CLINICAL ASSESSMENT

EDUCATIONAL MAPPING

Alternate Caregiver Consent Form

I authorize the following indiv	idual(s) to bring in my children to their appointments:
Name:	Relationship to my child:
Name:	Relationship to my child:
I attest that the above named	individual(s) are all 18 years of age or older as of this date.
to, consent for testing, proced	ndividual(s) to consent to treatment for my children. This may include, but is not limited lures, and hospitalization. Dirksen Center for Neuropsychology, Ltd may relay any medical ecessary for the above named individual(s) to provide informed consent to the treatment.
	vill communicate any relevant information or concerns to the caregiver who brings in the cumstances, a follow up call to me personally should not be necessary.
=	for Neuropsychology, Ltd and its staff harmless for any disagreement between the above If regarding treatment decisions.
I attest that I am the parent o agreement. I understand that	r legal guardian of the following child and that I have the legal authority to make this I can revoke this at any time.
Child covered by this consent	(list full name and date of birth):
Child:	Date of Birth:
Valid From: date	to date
Parent/guardian's name:	
Signature:	
Date:	
Witness:	
Date:	