JEVS PA START Philadelphia Consent for Evaluation and Treatment

Name of Individual: _____
Print Name

Date of Birth: _ _ / _ _ / _ _ _ _
M M D D Y Y Y Y

Please check the appropriate sentence below:

☐ I consent to the JEVS PA START Philadelphia Team providing evaluation and treatment services.

☐ I do not consent to the JEVS PA START Philadelphia Team providing evaluation and treatment services.

_____ _____
Signature of Person Consenting *Relationship to Individual*

_____ **Date:** _ _ / _ _ / _ _ _ _
Print Name M M D D Y Y Y Y

Address: _____
House # & Street Name *City, State and Zip Code*

Phone: (_____) _____
Area Code Number