

**CONSENT FORM****UNIVERSITY COUNSELLING SERVICE  
UNIVERSITY OF THE WEST INDIES**

Contact the following two people listed below in case of emergency.

1. [ ] Family member/[ ] friend: \_\_\_\_\_

Address: \_\_\_\_\_

Work phone #: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

2. [ ] Family member/[ ] friend: \_\_\_\_\_

Address: \_\_\_\_\_

Work phone #: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

I, \_\_\_\_\_, have read the guidelines regarding the process and rules of counseling. I have provided the names of two persons who are to be contacted in case of an emergency. My signature below acknowledges this, and also allows for the release of relevant information. I understand that it may be necessary to release relevant information under the following circumstances:

- (a) to ensure appropriate medical treatment and/or
- (b) in situations where my counsellor determines that I am a danger to myself or others
- (c) where a child is suspected of being in need of care and protection, as stated in the Child Care and Protection Act (2004)
- (d) where such data is to be used for research purposes and will not reveal my identity.

My signature below also acknowledges my agreement with these terms and conditions.

Client (or authorized person, e.g. parent): \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_