CONSENT FOR TREATMENT OF MINOR

Date: _____

I hereby authorize: _____

Doctor's Name

and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

_____

Minor Patient's Name

_____

Printed Name of Parent or Guardian

_____ _____

Signature of Parent or Guardian Date

_____ _____

Witness Date

Parent Remarks**:** _____

_____

_____

_____