

# CONSENT FOR TREATMENT OF MINOR

Date \_\_\_\_\_

I hereby authorize:

\_\_\_\_\_

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

\_\_\_\_\_

Minor Patient's Name

No.

\_\_\_\_\_

Signature of Parent or Guardian

Date

\_\_\_\_\_

Witness

Date

Remarks: \_\_\_\_\_

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