healing HANDS
FAMILY CHIROPRACTIC

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Authorization and Consent to Treat a Minor

Date: ____/____/____

Patient Name: _____ Patient Date of Birth: ____/____/____

The undersigned does hereby authorize the doctor(s) at Healing Hands Family Chiropractic the consent to perform a chiropractic health care screening, examination, and/or manipulative therapy or sports physical to the above-mentioned minor. It is understood that a parent or a guardian must present for the complete duration of this examination.

By signing this consent form the legal parent or guardian agrees that he or she was properly informed about the procedures that will take place during the above-mentioned services, and that his or her questions have and concerns have been addressed fully and to satisfaction.

_____
Printed Name

_____ _____
Signature of Parent or Guardian Date

Important Medical Information (allergies, medications, etc.):

_____
_____
_____
_____