Essington
FAMILY CHIROPRACTIC

CONSENT TO TREATMENT OF A MINOR

Minor's Name: _____ DOB: _____

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I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize **[Your Full Practice Name]** to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at **[Your Full Practice Name]** which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian (please spell clearly): _____

Relationship to the minor: ☐ Custodial Parent ☐ Adoptive parent with custody

☐ Guardian by Law. Date Guardianship Commenced: ___/___/___

☐ Other (please specify): _____

Social Security # of Parent/Guardian: ☐☐☐☐☐☐☐☐☐ Date of Birth: __/__/__

Address of Parent/Guardian: _____

Home Phone #: (____) _____

Signature: _____ Date: ___/___/___

Witness (if any)

Witness' Name: _____

Witness' signature: _____ Date: ___/___/___