

**AUTHORIZATION FOR CONSENT TO TREATMENT OF A MINOR**

Authorization is given to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to consent to chiropractic treatment

 (Name of responsible adult)

for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if I (we) the parent(s) or guardians are not available at the time of

 (Name of Child)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s scans, x-rays, adjustments or therapies. I (we) accept responsibility for all

 (Name of Child)

charges related to any scans, x-rays, adjustments or therapies rendered by reason of this authority.

Time frame for use of this consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (If no date indicated, effective for 12 months from date below)

Child’s birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_

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