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Consent for Care of a Minor

(Under 18 years old)

Date: _____/_____/_____

RE: _____
(type of study)

I, _____, as ▢ parent ▢ guardian of_____
(your name) (check one) (name of minor)

Born _____/_____/_____and anatomical gender is: ▢ Male ▢ Female.
(Date of Birth) (optional)

I give permission, and consent to treat with chiropractic care and/or medical care for the above named minor. I give permission to review records, imaging studies. and consult with other healthcare providers for the same minor. **Initial: _____**

Therapy(s) may consist of the following:

1) Chiropractic manipulation therapy.
2) Soft tissue therapy.
3) Electrical therapy.
4) Stress reduction therapy.
5) Exercise therapy and instructions in same.
6) Instructions for home therapy.
7) History, Examination, and Testing.

I agree to the above therapies as care for the above named minor whose age is: _____.

Signed by _____ Dated:_____/_____/_ _____.
(Full Name of Parent or Guardian)