Chiropractic Professional Center
10903 Indian Head Hwy #506
Fort Washington, MD 20744

Consent Of Treatment Of Minor

(I)(We), the undersigned, parent(s)/person having legal custody/ legal guardianship of _____, a minor, do herby authorize_____
(Name of minor) (Name of agent)
as agent(s) for the undersigned to consent to any x-ray, examinations, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____, unless sooner revoked in writing delivered to the agent(s) noted above.

Mother's Name
_____
Mother's Cell Phone Number
( )_____-_____

Father's Name
_____
Father's Cell Phone Number
( )_____-_____

Consent to give the following people permission to bring your child in for treatment other than yourself:

1) Name:_____
Number: ( )_____-_____
Relationship to minor:_____

2) Name:_____
Number: ( )_____-_____
Relationship to minor:_____

3) Name:_____
Number: ( )_____-_____
Relationship to minor:_____

Signature: _____
(Parent)

Signature: _____
(Parent/legal guardian/person having legal custody)(Circle relationship)

Date: _____