LEGACY
CHIROPRACTIC
& WELLNESS

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CONSENT TO TREAT A MINOR

Patient's Name: ________________________________ DOB:________________

Parent / Guardian Name: ____

Cell # ______________________ Email: _________________________________

I, (print name) ________________________________, the undersigned, being the parent / guardian of the above referenced minor, consent to and request that he/she be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C.). Services rendered may include but are not limited to, applicable x-rays, examinations, evaluations, diagnosis, and treatment as indicated and/ or recommended by and under the supervision of any licensed Doctor of Legacy Chiropractic and Wellness.

Signature of parent /guardian: ______________________________________

Printed Name of parent / guardian: ___________________________________

Date signed: ____