



chiroTrendz
family chiropractic and wellness center
keeping things in motion

Parental/Guardian Consent to Examine/Treat Minor

Date _____

Child's Full Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Sex Male Female
Your Cell Phone _____ Home Phone _____ Work Phone _____

To the Parent/Guardian of Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions if there is anything that is unclear before you sign. This document is intended for you to give us permission to examine and treat your minor child that is under the age of 18.

I hereby authorize the following conditions regarding the treatment of my minor child as deemed appropriate by the doctors and staff at ChiroTrendz Family Chiropractic and Wellness Center. I intend this consent to cover any examinations and treatments for my minor child's present condition and for any future condition. I understand that at any time I may rescind this consent at which time I will be asked to sign the bottom of this form.

Examination and Treatment of my minor child:

- IN MY ABSENCE until I notify the office of any changes.
- IN MY ABSENCE on these dates only: _____
- IN MY ABSENCE for _____ treatments.
- IN MY ABSENCE for the following duration of time: _____

Signature of Parent/Guardian_____
Printed Name of Parent/Guardian_____
Date

I hereby rescind or decline the examination and treatment of my minor child in my absence until further notice effective from the date of signature below.

Signature of Parent/Guardian_____
Printed Name of Parent/Guardian_____
Date