CONSENT TO TREATMENT OF A MINOR

Minor's Name: _____
DOB:_____ Age:_____

I hereby authorize Kelling Chiropractic Center and whomever they may designate as doctors or assistants to examine and administer treatment as they deem necessary to the minor listed above.

Name of Custodial Parent/Legal Guardian:_____

Address of Parent/Guardian:_____
_____

Home phone:_____ Work phone:_____

Relationship to the minor:

☐ Custodial Parent ☐ Adoptive parent with custody

☐ Guardian by Law. Date Guardianship Commenced: ___/___/___

☐ Other (please specify): _____

Signature: _____ Date: __/__/__

Witness' signature: _____ Date: __/__/__