Farmington Chiropractic
32738 Grand River Ave.
Farmington, MI 48336
P: 248-615-1381

CONSENT TO TREAT MINOR

I, _____, the Legal Parent/Guardian of:

Child's Name _____ Birthdate _____ Relationship to Child_____

Child's Name _____ Birthdate _____ Relationship to Child_____

Child's Name _____ Birthdate _____ Relationship to Child_____

Child's Name _____ Birthdate _____ Relationship to Child_____

Hereby request and authorize: Dr._____, to administer chiropractic care as he/she deems necessary for my minor child(ren) listed above. This authorization also extends to all other doctors and office staff members at Farmington Chiropractic and is intended to include diagnostic imaging and other treatment at the doctor's discretion.

I acknowledge that I have the right to amend this consent at any time and must notify the office immediately if my authority to authorize care is modified or revoked. To update or revise the terms of this agreement, it is my responsibility to inform the front desk and request an updated consent form.

Individual(s), that *are not* legal parents/guardians, *allowed* information and/or to bring to appointments for care (grandparents, older siblings, aunt/uncle, etc.)

Name: _____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____