Gallatin Chiropractic Clinic

CONSENT TO TREAT A MINOR

I give permission to the chiropractors and assistants with Gallatin Chiropractic Clinic to treat my child.

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the chiropractors/assistants to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

2. Medical concerns

_____

3. Known allergies

_____

4. Medications

_____

Name of Parent / Legal Guardian: _____

Name of Child: _____

Contact Number(s): _____

Signature: _____ Date: _____

*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork.

This Consent is effective until withdrawn in writing by the child's parent/guardian or until child turns 18 years of age.

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