



Consent to Examine/Treat a Minor Child

Mr. / Mrs. _____ is/are the parent (s) / guardian (s) of _____, a minor child, and has/have consented to the examination of the minor child and will be present during the examination. I/we have also been informed of the examination findings and proposed treatment plan and give his/her/ their informed consent for treatment to be initiated as of the date below. I/we also give permission for emergency Chiropractic treatment of my/our child, for illness or accident in the event that I cannot first be contacted.

Signature of Parent/Guardian

Date

We would like to keep you updated on the progress of your treatment along with sending you tailored exercise and stretches for your treatment. Your email address is solely confidential to Spinal Rehab and Wellness Center.

Email Address: _____