Consent for Chiropractic Treatment on a Minor Child

Name of minor patient: _____ Date of Birth: _____

I certify that I am the parent and/or legal guardian of_____ _____ and I consent to the rendering of chiropractic care, including diagnostic procedures, x-rays and treatment given by the doctor named below and/or other licensed Doctors of Chiropractic working at this clinic.

This authorization:

☐ is effective on_ _____ .

☐ is effective from _____ to _____ .

☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home phone number (_____) _____ - _____

Office phone number (_____) _____ - _____

Cell phone number (_____) _____ - _____

Other phone number (_____) _____ - _____

I reserve the right to revoke this authorization at any time by writing to the below-named physician.

_____ _____

Parent/Guardian Signature Date

Main Street Chiropractic
Charles L. Lennon III, DC
301-B Main Street • North Myrtle Beach • SC • 29582

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