

Consent to X-Ray (Minor)

Name of minor patient: _____ Date of Birth: _____

I hereby authorize Lennon Chiropractic Center to take x-rays that are necessary in this minor's chiropractic care.

Dated this ____ day of _____

Signature of Parent/Guardian: _____

Witnessed: _____

I hereby understand that gonadal shielding protects the radiosensitive reproductive tissue and agree to allow minor to be x-rayed without such shielding.

Signature of Parent/Guardian: _____

Witnessed: _____

Pregnancy Release* (Minor)

Not applicable - male patient

The 10 days following the start of each monthly menstrual period are generally considered safe for x-ray examinations.

I recognize that if the minor is pregnant and has radiation to the abdomen, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that the doctor feels that the information to be gained from this examination is important to the health of the minor. I therefore wish to have this x-ray examination performed now.

Start of last menstrual period, Date: _____ Date today: _____

Is minor pregnant? Yes No Don't Know

Has minor had a hysterectomy? Yes No Don't Know

Does minor use an IUD? Yes No Don't Know

* Must be completed for all minor female within the years of their menstrual cycle.

Signature of Parent/Guardian: _____

Witness: _____