



Consent to Treat a Minor

The Information I have given this office is complete and true to the best of my knowledge. I authorize the doctor and staff of Fox Chiropractic & Wellness Center to administer such procedures & treatment to _____(minor's name) as necessary.

I certify that I have authority and responsibility to authorize treatment for this child.

INFORMED CONSENT: I understand that chiropractic care is extremely safe; however I also understand that certain risks associated with any form of health care treatment. I accept that risk in order that he/she may receive treatment by the Doctor and Staff of Fox Chiropractic and Wellness and agree to hold then harmless off consequences thereof.

Print Patient Name _____

Parent's Signature _____ Date _____

Witnessed by _____ Date _____