



Date _____

Minor's Full Name _____ Date of Birth _____ Sex Male Female
 Address _____ City _____ State _____ Zip _____
 Your Cell Phone _____ Home Phone _____ Work Phone _____

Parental/Guardian Consent to Examine and Treat Minor

This document is intended for you to give us permission to examine and treat your minor child that is under the age of 18 in the absence of a parent or legal guardian.

I hereby authorize the examination and treatment of my minor child as deemed appropriate by the doctors and staff at JayMac Chiropractic.

I intend this consent to cover any examinations and treatments for my minor child's present condition and for any future condition.

I understand that the doctors will also communicate with me periodically regarding my child's treatment and will keep me informed of my child's progress.

I understand that at any time I may rescind this consent by notifying JayMac Chiropractic in writing by signing the bottom of this form.

 Signature of Parent/Guardian

 Printed Name of Parent/Guardian

 Date

I hereby rescind or decline the future examination and treatment of my minor child in my absence until further notice effective from the date of signature below.

 Signature of Parent/Guardian

 Printed Name of Parent/Guardian

 Date