CONSENT FOR TREATMENT (MINOR)

PATIENT NAME:_____

I hereby request and authorize Yerkey Chiropractic Health Center, Inc. to perform diagnostic tests and render chiropractic manipulation and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse, or other parent to the above described care is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

NAME: _____
(please print)

SIGNATURE: _____

DATE: _____

WITNESS: _____

RELATIONSHIP TO PATIENT: _____