Renegade Chiropractic
8243 Fairway Drive, Rogers AR 72756
479-352-4345 RenegadeBoneSetter@gmail.com

CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of

_____, a minor, do hereby authorize Dr. Chuck Turkowski D.C.
(name of minor)

as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

Date: _____

Signature: _____
(parent/legal guardian/person having legal custody) (circle relationship)

Print Name: _____