Dr. Michael Zdilla
1179 Rostraver Road - Belle Vernon - PA 15012
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p. 724.929.6777 - f. 888.221.7407

Patient Name: DOB:

Consent for Treatment of a Minor

I hereby authorize Zdilla Family Chiropractic, and whomever they designate as their assistants, to perform diagnostic tests, including but not limited to x-rays, and to administer treatment as they deem necessary to my (indicate relationship of child)_____, (child's name)_____.

_____ _____

Guardian Print Date

_____

Guardian Signature

Authorization to Treat Minor Patient in Absence of Parent/Guardian

I certify that I am the parent and/or legal guardian of _____
(name of child)

□ I authorize _____ to bring my child to office visits at Zdilla Family Chiropractic
(name of person bringing child to office)

□ I authorize the minor child named above to come alone to office visits at Zdilla Family Chiropractic

and I consent to the examination and/or treatment of my child.

This authorization:

□ is effective on _____

□ is effective from _____ to _____

□ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home Phone # _____ Office Phone# _____

Cell Phone # _____ Other Phone # _____

I reserve the right to revoke this authorization at any time by writing to Zdilla Family Chiropractic.

_____ _____

Parent/Guardian Signature Date

* A Photocopy of this authorization will be treated in the same manner as the original*