Dr. Michael Zdilla
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Consent for Chiropractic/Spa/Massage Treatment of a Minor

I hereby authorize Zdilla Family Chiropractic, and whomever they designate as their assistants and employees, 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/treatments at Zdilla Family Chiropractic

(name of person bringing child to office)

□ I authorize the minor child named above to come alone to office visits/treatments 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*