Patient Name: ______________________________

CONSENT TO TREAT MINOR CHILD

I hereby request and authorize Manchester Chiropractic & Sports Injuries, PLLC to perform diagnostic tests and render chiropractic adjustment and other treatment to _______________________________.

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 legal right to select and authorize health care services for the minor child named above.

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

___________________________________ ____________________________

Date Signature

___________________________________ ____________________________

Witness Printed Name

____

Relationship to Patient

70 Queen City Avenue | Manchester, NH 03103 | Office: 603-624-9480 Fax: 603-647-2023