



CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Dr. Todd McDougle and whomever he may designate as his assistant or authorized representative, to administer Chiropractic care as he deems necessary to my dependent minor child. This authorization also extends to include therapeutic care, diagnostic imaging, laboratory and other testing at the doctor's discretion.

Child's Name: _____

Relationship to Child: _____

As of today's date, I have the legal right to select and authorize health care service for the minor 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 is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Today's date: _____ City/State: _____

Signature of Parent/Guardian: _____

Print name of Parent/Guardian: _____

Witness: _____