Consent to Treatment of a Minor

I hereby request and authorize Dr. Trenton Scott, Dr. Scott Hessler, Dr. Stacie Howell and whomever he/she may designate as his/her assistant or authorized representative, to administer chiropractic care as he/she 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 names 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:____