CONSENT TO TREAT A MINOR

I, _____, hereby authorize the doctors and staff of Sheppard Spine and Sports Clinic to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor child: _____.
(Child's Name)

I certify that I have authority and responsibility to authorize treatment for the child.

INFORMED CONSENT: I understand that chiropractic care is extremely safe: however I also understand that there are certain risks associated with any form of health care treatment. I accept that risk in order that he/she may receive treatment by the Doctors and Staff of Sheppard Spine and Sports Clinic.

Signature:_____
(Parent or Legal Guardian)

Printed Name:_____
(Parent or Legal Guardian)

Relationship to Patient: _____ Date:_____