FREEPORT FAMILY CHIROPRACTIC
TREATMENT OF MINOR CONSENT

I hereby authorize Dr. Jennifer L. Laird and whomever she may designate as assistants to perform diagnostic test and render chiropractic adjustments and other treatment to MY MINOR CHILD: _____.

_____ I give Freeport Family Chiropractic Clinic the right to (adjust/examine/x-ray/massage/and perform physical modalities on) my child **without** a parent or legal guardian being present.

As of this 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.

Date: _____ Signature: _____

Witness: _____ Printed Name: _____

Relationship to Patient: _____

Notarization:

On this _____ day of _____, _____, _____
DAY MONTH YEAR NAME OF PATIENT

personally appeared before me in _____ County (in the state of _____)
and, in my presence, signed this minor's consent form.

Name of Notary Official: _____

Signature: _____

Commission Expires: _____