Integrity Chiropractic
Live Better Naturally

Consent to Treatment of a Minor

(I/We), the undersigned, parent(s)/person having legal custody/legal guardianship of

_____, a minor, born on _____
(Full Name of Minor) (DOB)

do hereby authorize Dr. Jodi L. Kennedy D.C, & Integrity Chiropractic as agent(s)

For the undersigned to consent to any and all examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor and rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required.

Additional permission is granted to treat the minor listed above, in the absence of the parent or legal/guardian if he/she is 12 years of age or older? ( ) Yes ( ) No

Name of Parent or Guardian: _____
Parent/legal guardian (circle relationship)

Signature of Parent or Guardian: _____

Date: _____

Signature of Doctor: _____

Dated: _____