Consent to Treatment of a Minor Child

I hereby authorize:

Dr. Nielsen and whomever he may designate as assistants to administer chiropractic care as deemed

necessary to my _____ (indicate relationship to child).

Please mark one of the following options:

□ YES, my child may receive chiropractic care without a parent/guardian present.

□ NO, my child may not receive chiropractic care without a parent/guardian present. I understand that if my child arrives for an appointment unaccompanied he/she will not be seen.

_____
(Name of Child)

Dated at, _____, _____
(City) (State)

This day _____ of, _____
(day) (Month) (Yr)

Signed: _____
(Parent or Guardian)

Witnessed: _____