Strickland Chiropractic Center

Dr. J Lee Strickland

Consent for Treatment of a Minor Child

DATE: ___________

Parent/Guardian Name:_________________________________

Name of Minor: _______________________________________

Relationship to Child: __________________________________

Home Phone: _________________________

Address: ____________________________________ Cell Phone :_________________________

City: ____________________________ State: _________

Zip Code: ________________

Parent/Guardian DOB: ___________ Age: ________ (Check One) M __ F__

Email: ____________________________________

Employer: ________________________________ Occupation: _________________________

Work Phone: _______________ Ext: _______

City: ________________________ State: _________

Zip Code: ________________

I hereby authorize:
Dr. _______________________ to administer chiropractic care as deemed necessary to my _______________________ (Indicate relationship to child), __________________ (name of child) this ______________ day of ___________________, 20___.

Signed: ___________________________ Printed: ________________________________

Date: _____________________