

AUTHORIZATION FOR TREATMENT OF A MINOR

MINOR'S NAME _____

DATE OF BIRTH _____

I/we, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the doctors of Cernosek Chiropractic Health Services to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, medical or chiropractic diagnosis, and any consultation deemed necessary at the doctor's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the doctor to exercise his or her best judgement as to the requirements of such diagnosis or medical/chiropractic treatment in my/our absence.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s), or until child may legally consent for him or herself.

Signature-Parent of Legal Guardian

Date

Signature-Parent of Legal Guardian

Date

Witness

Date