CONSENT TO TREATMENT OF MINOR CHILDREN

Advanced Spine & Rehab / Advanced Family Healthcare

The purpose of this instrument is to give Advanced Spine & Rehab / Advanced Family Healthcare the power and authority for medical and/or chiropractic treatment. This power and authority will be effective as of the below date and remain in effect until it is revoked in writing.

EFFECTIVE DATE (*Today's Date*):

_____

Minor Patient's Full Name: _____

Date of Birth: _____

PARENT or LEGAL GUARDIAN'S PRINTED NAME: _____

PARENT or LEGAL GUARDIAN'S SIGNATURE: _____

Is your child allergic to any medications? Yes / No (*Please circle one*) if yes, please list:

_____

Is your child currently taking any medications? Yes / No (*Please circle one*) if yes, please list:

_____

PARENT or LEGAL GUARDIAN INFORMATION

Address: _____ Apt/Space #: _____

City: _____ State: _____ Zip Code: _____

E-mail address**:** _____

Provide all phone numbers: Home: _____

Cell: _____ Work: _____