Consent to Treatment of a Minor Child

I hereby authorize:

Dr. Lofton and whomever she 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)

Emergency Contact

Name: _____

Relationship to child: _____

Phone Number: _____

Dated at, _____, _____

(City) (State)

This day _____ of, _____

(Day) (Month) (Year)

Signed: _____

(Parent of Guardian)

Witnessed: _____