CONSENT TO TREAT A MINOR PATIENT

Asula Chiropractic and Wellness Center

I, _____ , parent of legal guardian of
(print your Firstname, Lastname)

_____ **born** _____ **,**
(print minor Firstname, Lastname) (mm/dd/yyyy)

do hereby consent to any medical care determined by the treating Practitioner to be necessary for my child while said child is under the care of Asula Chiropractic and Wellness Center.

If minor is age 14 and under, I agree to stay on premise for all appointments. If minor is over the age of 14, I give consent for said child to be under the care of the treating Practitioner while I am not on premises.

Asula Chiropractic and Wellness Center agrees to release all medical records of the child when requested by parent or guardian. All treating Practitioners also agree to discuss the care and progress of said child with parent or guardian.

This authorization is effective from: _____
(date)

Parent or Legal Guardian Signature: _____

Witness Signature: _____

Witness Name (PRINT): _____

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