Child

Full Legal Name: ____

Date of Birth: _______________________ Age: ___________ Gender: __________

Parent(s)/Legal Guardian(s):

Parent #1:

Name:____

Address: ____

Home phone: __________________________ Work phone: __________________________

Cell phone: ____________________________

Parent #2:

Name:____

Address: ____

Home phone: __________________________ Work phone: __________________________

Cell phone: ____________________________

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for doctors and staff and Great Lakes Chiropractic to treat, examine and/or x-ray if necessary.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the child in the exercise of his or her best judgment upon the advice of the doctors and staff of Great Lakes Chiropractic. I understand that as the parent, I am still responsible for payment for services rendered to the above mentioned minor.

____ ___________________

Parents Signature Date