



CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby consent to chiropractic treatment determined by the chiropractic physician to be necessary for the welfare of my child while said child is under the care of Function First Spine and Sport, PLLC and I am not present at the appointment.

This authorization is effective for the duration of the treatment plan.

Signature of Parent or Legal Guardian

Date:

Witness Name (please print)

Witness Signature