

# CONSENT FOR TREATMENT OF MINOR

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Date: \_\_\_\_\_

I hereby authorize Dr. Alexander Hernandez and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

\_\_\_\_\_  
Minor Patient's Name

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Parent Remarks: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_