Madison Heights Chiropractic Center

28107 John R Madison Heights, MI 48071 **248-542-3492**

Minor / Child Consent Form

I am the parent, guardian, or personal representative of ________________________________
(Please print name of minor / child)

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, which are deemed advisable by the doctor.

___________________________________ ____________________
Signature of Patient, Parent, Guardian or Personal Representative Date

___________________________________ ____________________
Please Print Name of Patient, Parent, Guardian or Personal Representative Date

____ (initial) I request that my child be able to maintain their chiropractic appointments without the presence of a parent/guardian when necessary. **(This applies to children 14 years of age or older.)**

___________________________________ ____________________
Signature of Patient, Parent, Guardian or Personal Representative Date

___________________________________ ____________________
Witness Signature Date