Range of Motion Chiropractic

CONSENT FOR TREATMENT OF A MINOR

I (We) the parent(s) or guardian(s) of _____, a minor the age of _____ do hereby consent, authorize and request the Doctors of Chiropractic Medicine at Range of Motion Chiropractic, to administer such treatment deemed advisable, necessary or requested on the about minor.

I (We) agree to hold Range of Motion Chiropractic free and harmless from any claims, suits for damages or complications, which may result from treatment without prior mediation.

X_____
Print Parent/Legal Guardian Name

X_____
Patient/Legal Guardian Signature

X_____
Date