Jackson Chiropractic Clinic
3508 Rice Street
Shoreview, MN 55126
(651) 483-4321

**Authorization for Care of a Minor**

Patient's Name _____ Date of Birth _____

Parent/Guardian Name(s) _____

Relationship _____ Phone Number _____

I, hereby, authorize Jackson Chiropractic Clinic to render any chiropractic services necessary for the treatment of _____. These services include but are not limited to: physical examination, x-rays, chiropractic adjustments, therapeutic procedures, traction, electric muscle stimulation, and manual muscle work, within the scope of chiropractic practice.

I, hereby, give consent for _____ to be treated even if I or another parent is unable to attend the chiropractic visit. As a parent/guardian, I am financially responsible for any services rendered during the visit. Any questions or concerns can be directed toward the treating doctor at any time.

Parent/Guardian Signature _____ Date _____

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As a Doctor of Chiropractic, we will perform services to the best of our ability, upholding the integrity of our practice. We will treat the patient with respect and only perform services we deem necessary for the treatment of the condition.

Doctor Signature _____

Doctor Name _____ Date _____