Great Lakes Chiropractic of St. Michael
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

CONSENT FOR EVALUATION AND TREATMENT OF A MINOR WITHOUT PARENT/LEGAL GUARDIAN PRESENT

USE FOR MINOR COMING ALONE (SIGNED IN ADVANCE)

I, _____ having legal custody of
Printed Name of Parent or Legal Guardian

of _____ whose birth date is _____,
Printed Name of Minor Date of Birth

give permission to Great Lakes Chiropractic of St. Michael to provide chiropractic care to my child while I am not present at the appointment.

I authorize Great Lakes Chiropractic to act on my behalf in case of an emergency. If this occurs, Great Lakes Chiropractic will make diligent efforts to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize Great Lakes Chiropractic to take appropriate and necessary actions to care for my child. I also agree that I will be responsible for the charges that result from my child's care.

This consent is valid from date I sign this consent, until I either notify Great Lakes Chiropractic in writing that it is no longer in effect, or my child turns 18 years old, whichever occurs first.

_____

Signature of Parent or Legal Guardian Phone Number Date

USE FOR MINOR ACCOMPANIED BY ANOTHER ADULT (SIGNED IN ADVANCE)

I, _____ having legal custody of
Printed Name of Parent or Legal Guardian

of _____ whose birth date is _____,
Printed Name of Minor Date of Birth

authorize the caregiver(s) listed below to accompany my child to clinic appointments, receive my child's medical information, and consent to chiropractic care for my child.

_____ _____
Name of Caregiver (Print) Caregiver Phone Number

_____ _____
Name of Caregiver (Print) Caregiver Phone Number

This consent is valid from date I sign this consent, until I either notify Great Lakes Chiropractic in writing that it is no longer in effect, or my child turns 18 years old, whichever occurs first.

By signing this consent, I agree that Great Lakes Chiropractic may disclose health information about my child to the listed caregiver(s) for the timeframe I indicated above. I also agree that I will be responsible for the charges that result from my child's care. I understand that I may revoke this consent by sending a written request for cancellation to Great Lakes Chiropractic, and that the cancellation will take effect when the written request is received.

_____

Signature of Parent or Legal Guardian Phone Number Date