



1484 OH-46N Ste. 7  
Jefferson, OH 44047  
Phone: (440) 624-4214  
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### Consent Form to Treat a Minor

Patient Name: \_\_\_\_\_

I hereby request and authorize the Chiropractors and Therapists employed by Davis Family Chiropractic LLC to perform diagnostic tests and render treatment to the patient named above.

As of this date, I have the legal right to select and authorize healthcare services for the minor child named above.

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

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Witness: \_\_\_\_\_