

# Consent to Treatment of a Minor



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

I hereby authorize Dr. Andrew Bakken to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor son/daughter: \_\_\_\_\_. This authorization includes treatment to be administered at the office in Racine listed below.

Dr. Andrew Bakken  
Practice of Chiropractic  
Back-In-Action  
1524 Green Bay Rd.  
Racine, WI 53406  
262- 884-7580

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

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse / former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Dr. Bakken.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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

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