I, _____ hereby give permission for _____ to examine and perform chiropractic adjustments and adjunctive therapies on my child _____. I recognize that I will be made aware of any exam findings, and reserve the right to be present during any treatment provided to my child. I also request the doctor to contact me regarding any changes or concerns regarding my child's condition.

My child's condition is to be given complete confidentiality. Charges for services provided outside the provider's office are performed gratis.

_____
Printed Name of Parent

_____
Signature of Parent

_____
Date