Back To Wellness

Dr. Trevor Lee Chalfant
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CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize **BACKTOWELLNESS** as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by Dr. Trevor Lee Chalfant, be rendered under the general or special supervision of Dr. Trevor Lee Chalfant. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. This authorization shall remain effective until ___/___/___, unless sooner revoked in writing delivered to the agent(s) noted above.

Date: ___/___/___

Signature:_____
(parent/legal guardian/person having legal custody) (circle relationship)

Signature:_____
(parent/legal guardian/person having legal custody) (circle relationship)

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