AUTHORIZATION TO TREAT A MINOR

The following form is designed for those situations where minors are unaccompanied by either parent or legal guardians. This "Medical Treatment and Authorization and Consent Form" gives authority to a designated adult to accompany the minor to office visits.

- Minor's Full Name: _____
- Minor's Address: _____
- City, State, Zip Code: _____
- Minor's Date of Birth: _____

Designated Adults:

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

The undersigned do hereby authorize Dr. Elizabeth Crumbaugh, DC of Live Well Chiropractic to provide medical treatment of the above-named minor in the absence of a parent or guardian as long as the minor is accompanied by a designated adult listed above.

Parent or Guardian Signature: _____Date_____

Parent or Guardian (Please print) _____