CONSENT TO TREAT A MINOR CHILD

2105 E. Clairemont Avenue, Eau Claire, WI 54701
Phone: (715) 835-9514 Fax: (715) 835-2602

Responsible Party Information:

First_____ MI_____ Last_____ ☐Male ☐Female

Address_____ City_____ State_____ Zip_____

Social Security #_____ Date of Birth_____/_____/_____ Age_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated Spouse's Name_____

Phone: Home (_____) _____ Cell (_____) _____ Email Address_____

Work (_____) _____ Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

I hereby authorize the Chiropractors at Stucky Chiropractic Center, S.C. to administer treatment as deemed necessary to my:

☐ Son

☐ Daughter

☐ Dependent

Patient Name: _____

Parent or Guardian Signature: _____

Date: _____

Witnessed By: _____