INFORMED CONSENT TO TREATMENT
For Minor

The undersigned is the parent or legal guardian of the minor _____ who explicitly and specifically consents to the treatment of said minor.

Doctors of chiropractic, chiropractic assistants and massage therapists who use manual therapy techniques such as spinal adjustments, kinesio-taping/strapping, cryotherapy, neuromuscular reeducation, massage, should advise patients that there are or may be risks associated with such treatment. In particular, you should note:

a) While rare, some patients have experienced rib fractures, muscle strains and/or ligament sprains **following spinal manipulation.**

b) There have been reported cases of stroke following **cervical spinal adjustments**. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in death. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

c) **Kinesio-Taping/Strapping, heat and cryotherapy (ice):** Skin reactions or burns

Chiropractic treatments, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches being and other similar symptoms. The risk for injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor and his staff the nature and purpose of the treatments in general and my treatment in particular (including spinal adjustments) as well as the contents of this Consent. I consent to the treatment offered or recommended to the minor child including spinal adjustments. I intend this consent to apply to all his/her present and future care.

TO BE COMPLETED BY PATIENT'S PARENT OR LEGAL GUARDIAN:

Date signed: _____

Parent or Legal Guardian Name: _____
(Please Print)

Parent or Legal Guardian Signature: _____

Patient Name: _____
(Please Print)

Witness Signature: _____