

Joliet Medical Center

815 N Larkin Ave Suite 105

Joliet, IL 60435

Phone: 815-714-2271

Fax: 815-582-3262

CONSENT FOR TREATMENT OF A MINOR

DATE: ____/____/____

I _____, Hereby authorize Joliet Medical Center
(To include all practicing Doctors/Practitioners and therapist) to administer
examinations, chiropractic care, and any therapeutic procedures they deem
necessary for:

Patient Name (Please Print): _____ Age: _____

DOB: _____

Additional Remarks:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Witness Name (please print): _____

Witness Signature: _____ Date: _____