

****

**HEALING**

**1132 Arcade Street, St. Paul, MN 55106 Phone: (763)458-6804 Fax: (651)771-4204**

**MINOR CONSENT FORM**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Whom It May Concern:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the parent/guardian of the minor named below, and I hereby authorize, and indeed give my permission to, **Healing Chiro Center, PLLC**, to provide care to the minor named below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minor Name** **Minor Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Name Parent/Guardian Signature**

**Dr. Jeremy Hurkman**

**Chiropractic Physician**