# Consent to the Treatment of a Minor

I, being the parent/guardian of ___________________________________ do hereby consent, authorize and request Dr. Darin Haworth DC, MS, CCSP® to administer such treatment deemed advisable, necessary or requested on the aforementioned minor. I understand that there may be side effects which may include minor bruising and soreness.

Treatment may include, but is not limited to: soft tissue manipulation, which may or may not include Instrument Assisted Soft Tissue Manipulation, chiropractic adjustments, including full spine and extremity adjustments, taping, nutritional counseling, patient education, and rehabilitation exercises.

Parent/Guardian Signature_______________________________________________

Parent/Guardian Name __________________________________________________

Phone number (_______)_______-_________

Patient Information

DOB___/____/_____ Gender: M / F (circle one)

Significant injuries/illnesses_______________________________________________

Physical Restrictions____________________________________________________

Current/Recent Medications_______________________________________________

For information about Dr. Darin Haworth's credentials and qualifications, please visit our website.

Summit to Shore Chiropractic
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