PATIENT NAME: ______________________________

Dr. Glen T. Matejka, D.N., D.C.
Suite 15
7105 N. Virginia Road
Crystal Lake, IL 60014
815-455-4500

CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Dr. Glen T. Matejka to perform diagnostic tests and render chiropractic and naprapathic adjustments and other treatment to the minor ______________________________. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for this minor named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of spouse/former spouse or other parent to the above described care is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date: ______________________________

Signature: ______________________________

Witness: ______________________________

Relationship to patient: ______________________