Tancredi Chiropractic & Physical Therapy Center

600 Reed Road, Suite 101
Broomall, PA 19008
610-353-9400
FAX 610-353-2280

CONSENT TO TREAT A MINOR CHILD

I hereby authorize **Dr. Michael J. Tancredi** and/or his staff at **Tancredi Chiropractic and Physical Therapy Center**, to examine, treat and prescribe diagnostic studies if deemed necessary on my minor child. _____.

Dr. Michael J. Tancredi, has fully explained treatments, and procedures pertaining to the minor child, _____ to me.

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

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

_____ _____
DATE SIGNATURE

_____ _____
WITNESS PRINTED NAME

_____
RELATIONSHIP TO MINOR PATIENT