PARKER UNIVERSITY
Chiropractic Clinics

PERMISSION TO TREAT A MINOR IN ABSENCE OF LEGAL PARENT AND/OR GUARDIAN

Policy: It is Parker University's policy that minors are accompanied by a legal parent / guardian or authorized person(s) (Age 18 or Greater) to receive services. By completing and signing this document, the legal parent and / or guardian authorizes Parker University, Chiropractic Clinics for the current episode of care (i.e., Chief Complaint) to examine, test, diagnose and treat their minor child in their absence via the person(s) identified below after the legal parent and / or guardian was (1) present for the initial visit, (2) present for the report of findings and (3) completion of the informed consent (separate form) as well as (4) completed this document in person at the Parker University clinic. The document expires (1) at the end of the episodic care (i.e., end of treatment plan that has not been renewed per clinic policy) or (2) patient has been released from care.

Parker University
Chiropractic Clinics
2600 Electronic Lane
Dallas, Texas 75220
www.parker.edu/clinics

Legal Parent / Guardian Authorization:

I (Legal Parent / Guardian) authorize Parker University, Chiropractic Clinic to perform examinations, tests, diagnosis and treatment for the current episode of care (i.e., Chief Compliant) in my absence to my minor child. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

I (Legal Parent / Guardian) authorize Parker University, Chiropractic Clinics to initiate First Responder Services in the event of an emergency health situation involving the minor child mentioned below.

As of the date, I have the legal right to select and authorize health care services for the minor child named below. (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, we will immediately notify this office.

I hereby give permission for my minor child:

Patient Name: _____ DOB: _____ File #: _____
To be transported, examined and treated for Subsequent Visits at Parker University Chiropractic Clinics in my absence by the following:
Name: _____ Relationship: _____

Name: _____ Relationship: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/ Legal Guardian: _____

Witness Print: _____ Signature: _____
Date: _____