

**Cynthia Smith Chiropractic and Acupuncture**

CONSENT TO CARE FOR A MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of

\_\_\_\_\_, a minor,  
(Name of Minor)

do hereby authorize

**Dr. Cynthia Smith of Cynthia Smith Chiropractic and Acupuncture** to exam and render any necessary care by a licensed chiropractor/acupuncturist.

It is understood that this authorization is given in advance of any specific diagnosis or care being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and care which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Print Parent Name

\_\_\_\_\_  
Date