Family Health Chiropractic
www.naturopathicliving.ca

Dr. S. Slipacoff, ND
info@naturopahticliving.ca

Hamilton Back Clinic
1600 Rymal Rd E, Hamilton, ON
905.692.4222

Consent to Treatment of A Minor

PATIENT INFO:

First Name: _____ Last Name: _____

Age: _____ Male: ☐ or Female: ☐

I AUTHORIZE _____, Doctor of Naturopathic Medicine, to examine and administer Naturopathic care and treatment to _____ whose relationship to me is as a _____.

I have been given an explanation of and understand the nature of the naturopathic medical care and treatment. I authorize _____, Naturopathic Doctor, to take whatever measures he/she considers necessary or desirable in connection with such Naturopathic care and treatment.

My name, address and telephone number, or that of another contact person for the patient (whichever is appropriate) is as follows:

_____

_____

_____

DATED at Bolton, in the Province of Ontario, this _____ day of _____, _____.
(month) (year)

_____ _____
Parent or Guardian of Minor – print name Signature