



CONSENT TO TREATMENT OF A MINOR

PATIENT INFORMATION:

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