CONSENT FOR TREATMENT OF MINOR

Date:	
I hereby authorize:	
Doctor's N	
and whomever he or she may designate as assistants	to administer examinations and
chiropractic care as deemed necessary to:	
•	
Minor Patient's Name	
Printed Name of Parent or Guardian	
	Date
Signature of Parent or Guardian	Date
Witness	Date
Day of Day of Land	•
Parent Remarks:	