CONSENT FOR TREATMENT OF MINOR CHILD

I HEREBY AUTHORIZE DR._____ TO ADMINISTER TREATMENT AS HE SO DEEMS NECESSARY TO MY SON/DAUGHTER:_____

DATED THIS_____DAY OF_____ 20_____

PARENT/GUARDIAN_____

WITNESS_____

PUYALLUP CHIROPRACTIC CLINIC
111 EAST STEWART AVENUE
PUYALLUP, WA 98372