CONSENT FOR TREATMENT OF MINOR

I (We) being the parent,guardian or custodians of ____________________
_____________________ a minor, the age of ______, do hereby authorize, request and direct Dr.__________________________________ to perform in his judgement any necessary examination, xray, and chiropractic treatment for the condition.

____
Parent, guardian or custodian

____
Date

____
Parent, guardian or custodian

____
Date

____
Witness

____
Date

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