

CONSENT TO TREATMENT OF MINOR CHILD

Effective relief for:

- Back, Neck, and Extremity Pain
- Headaches and Migraines
- Joint pain and muscle spasms
- Pregnancy discomfort
- Menstrual cramps
- Dizziness, nausea, and allergic reactions
- Scoliosis
- Sports, workplace, and automobile accident injuries
- Arthritis pain

I (we) being the parent or guardian of _____,

a minor, the age of _____, do hereby consent, authorize and

request that a doctor at the Great Health Chiropractic Clinic administer such

treatment deemed advisable, necessary or requested by the above minor.

Signed _____

Parent or Guardian

Comprehensive care:

- Full Chiropractic care
- Energizing massage
- Rehabilitation exercises
- Nutritional counseling
- X-Ray facility
- Physical therapy

Date _____

Witness _____

A tradition of care and convenience:

- Extended appointment hours
- Visa and MasterCard

Pub/doc/forms/consenttotreatminor