

Patient #: \_\_\_\_\_

# Bonsall Chiropractic

## Consent to Treatment of Minor Child

I hereby authorize Dr. \_\_\_\_\_ and whomever he/she may designate as assistants to administer treatment as deemed necessary to my \_\_\_\_\_ ,  
Son, daughter, etc.

\_\_\_\_\_  
Name

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ , 2 \_\_\_\_\_ .

Signed: \_\_\_\_\_

PARENT OR GUARDIAN

Reorder H. J. Ross Co. (714) 539-2130

Witnessed: \_\_\_\_\_