CONSENT TO TREATMENT OF A MINOR CHILD

I HEREBY AUTHORIZE McCLIMON CHIROPRACTIC OF BIRDSBORO, PA AND WHOMEVER HE MAY DESIGNATE AS ASSISTANTS TO ADMINISTER CHIROPRACTIC CARE AS DEEMED NECESSARY AND TO BE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED TO:

MY _____ (INDICATE RELATIONSHIP)

_____
NAME OF MINOR

DATE: _____

SIGNATURE: _____
PARENT OR LEGAL GUARDIAN

WITNESS: _____