

**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: \_\_\_\_\_