Wellness Chiropractic

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TREATMENT OF MINOR CHILD CONSENT FORM

I, _____ (parent/guardian),

hereby authorize Michael Aker, D.C., Dipl Ac(AACA), Sarah De Preter D.C., C.C.W.P., Matthew Thompson D.C., and whomever they may designate as assistants, to administer treatment as they so deem necessary to:

(name/relationship) _____.

DATE: _____

SIGNATURE: _____

WITNESS: _____