



# CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize the doctors and staff at Fox Valley Chiropractic Physicians to administer treatment as they so deem necessary to my daughter/son, \_\_\_\_\_.  
(Full Name of Minor)

\_\_\_\_\_  
Parent of Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

