CONSENT FOR TREATMENT OF MINOR

Date: ______________________

I hereby authorize Foster Chiropractic and whomever Dr. Foster may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

____
Minor Patient's Name

____
Printed Name of Parent or Guardian

____ ________________
Signature of Parent or Guardian Date

____ ________________
Witness Date

Parent Remarks: ____

____

____

____

Foster Chiropractic Clinic
Dr. Karl L. Foster, D.C.
2921 Long Prairie Road
Flower Mound, TX 75022
Ph: (972) 927-4357
Fax: (972) 539-4358