CONSENT TO TREATMENT OF MINOR CHILD

Newhall Family Chiropractic Clinic, P.C.
13 Main Street
Newhall, Iowa 52315

I hereby authorize:

Dr. Jacob Pudenz of Newhall Family Chiropractic Clinic, P.C. and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my

____________________________________ (Indicate relationship of child)

____ (Name of child)

Dated at Newhall, Iowa _______________ ______________ , 20______
Month Day

Signed: ____
Parent/Guardian

Witnessed: ____