**Consent for Chiropractic Treatment of a Minor Child**

(Under the age of 18)

I hereby authorize Dr. David Cartwright and whomever he may designate as assistants
to administer chiropractic care or therapies as deemed necessary to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of child).

He/She is my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (indicate relationship to child).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature