BACK TO WELLNESS CLINIC

113 FAIRPLAY ST **(706) 557-0211**
RUTLEDGE, GA 30663 **FAX (706) 557-0213**

CONSENT FOR TREATMENT OF A MINOR

I (We) being the parent, guardian or custodians of

_____

a minor, the age of _____, do hereby authorize, request and direct Dr. _____ to perform in his/her judgement any necessary examination, X-ray, and chiropractic treatment for the condition.

_____ _____

Parent, guardian or custodian Date

_____ _____

Parent, guardian or custodian Date

_____ _____

Witness Date