

M I R T S C H I N G D . C .

D E W A Y N E M .

DOCTOR OF CHIROPRACTIC

**CONSENT TO TREATMENT OF A MINOR**

I, the undersigned, hereby authorize Dr. DeWayne M. Mirtsching and whomever he may designate as his assistants to administer treatment as he so deems necessary to my

Son

Daughter

Print Child's Name

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

\_\_\_\_\_  
Date

Printed Name of Parent/Guardian

Witness