Croixview
FAMILY CHIROPRACTIC

Consent toTreatment of Minor Child

Patient:_____

I, hereby authorize ***Dr. Jennifer Krohn/Shupe D.C***. or ***Dr. Lauren Pettijohn D.C.*** and whomever they may designate as assistants to administer chiropractic

care as deemed necessary to my _____,

(indicate relationship to child)

_____.

(name of child)

Date: _____

Signature of parent/guardian: _____

Croixview Family Chiropractic

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