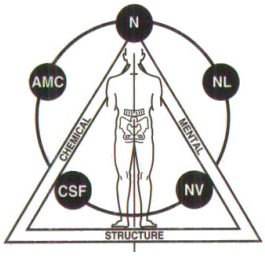

Dr. Alan P. Duben
Chiropractor
Applied Kinesiology, Nutrition

Consent for the Doctor to Treat a Minor

Parent or Guardian:

Please carefully print **your:**

NAME: _____

ADRESS: _____

_____

HOME PHONE: _____

WORK PHONE: _____

MINOR'S NAME: _____

AGE: _____SEX:_____

I (we) being the parent of guardian of the above named minor, do hereby consent, authorize and request Dr. Alan Duben to administer such CHIROPRACTIC and/ or NUTRITIONAL treatment as he deems necessary on the above named minor.

I (we) understand that Dr. Duben's recommendation and instructions for care and treatment must be complied with; otherwise the doctor cannot be held resopnsible or liable.

I (we) understand that there will be certain specific recommendations and procedures to follow for the care and treatment of the above minor. I (we) therefore agree to comply with the doctor's instructions by the total amount of care necessary until the patient is released by the doctor.

Parent/Guardian Signature:_____

Date:_____

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