MINOR TREATMENT AUTHORIZATION

I do hereby give permission for Kadin Family Chiropractic & Wellness Center, LLC Chiropractic to treat my minor children (listed below).

This will include any necessary X-rays needed.

Parent Name:_____

Street:_____

City/State:_____

Child: _____ Birth Date: _____ Age: _____ Sex: M / F

Child: _____ Birth Date:_____ Age: _____ Sex: M / F

Child: _____ Birth Date:_____ Age: _____ Sex: M / F

Child: _____ Birth Date:_____ Age: _____ Sex: M / F

Child: _____ Birth Date:_____ Age: _____ Sex: M / F

Child: _____ Birth Date:_____ Age: _____ Sex: M / F

Parent Signature:_____

Guardian Signature:_____

Witness: _____ Date: / /