



# **METCALF CHIROPRACTIC HEALTH CENTER**

15315 1<sup>st</sup> Ave NE Suite 5, PO Box 507, Duvall, WA 98019-0507 Ph.425-844-6428

**Dr. Jeffrey P. Metcalf**

## **CONSENT TO TREATMENT OF A MINOR**

I hereby authorize:

Dr. Jeffrey P. Metcalf to administer Chiropractic care as deemed necessary to

\_\_\_\_\_.  
(Name of child/minor)

\_\_\_\_\_  
Guardian's signature

\_\_\_\_\_  
Date

Guardian's relationship to minor: \_\_\_\_\_