METCALF CHIROPRACTIC HEALTH CENTER

15435 Main St NE, Suite 101, 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) Child/minor's date of birth

_____ _____

Guardian's signature Date

Guardian's relationship to minor: _____