CONSENT TO TREATMENT OF A MINOR

I __________________________________ hereby authorize Dr. Russell Schierling and whomever he may designate as his assistants to administer chiropractic care as he deems necessary to my SON / DAUGHTER / GRANDSON / GRANDAUGHTER / OTHER:_______________________
(circle one)

___________________________________ _____________________
NAME OF CHILD CHILD'S BIRTHDATE

DATED AND WITNESSED AT SCHIERLING CHIROPRACTIC, LLC

LOCATED IN MOUNTAIN VIEW, MISSOURI ON THIS _________

DAY OF ___________, IN THE YEAR OF OUR LORD 20____.

SIGNED BY:____
(PARENT OR GAURDIAN)

____
(PRINT NAME)