CONSENT TO TREATMENT OF MINOR CHILD

322 West 3rd street

Suite B

Carroll, IA 51401

Pudenz Family Chiropractic Clinic, P.C.

I hereby authorize:

Dr. Jason Pudenz of Pudenz Family Chiropractic Clinic, P.C. and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my

_____(Indicate relationship to child)

_____(Name of child)

Dated at Carroll, Iowa _____ _____ , 20_____

Month Day

Signed:_____

Parent/ Guardian

Witnessed:_____