



17323 I.H. 35 NORTH, SUITE 106
SCHERTZ, TX 78154
Ph: 210-646-6000 Fax: 210-651-0665

CONSENT TO TREAT A MINOR CHILD

I, _____, hereby authorize Dr. Patrick W. Martin, D.C.
and whomever he may designate as assistants to administer chiropractic care as
deemed necessary to my _____ (indicate relationship of child.)

_____ DOB: _____ / _____ / _____
(Full name of child)

Dated at _____, Texas
(City)

this _____ day of _____, 20____.
(Date) (Month)

Signature: _____

Printed Name: _____

Witnessed: _____

Printed Witness Name: _____