



3540 Stewart Ave, Wausau WI, 54401 | 1915 N 6<sup>th</sup> St, Wausau WI, 54403 | 715.842.3999

## Consent To Examine, X-Ray and Treat Minor Child

I hereby authorize (doctors name) \_\_\_\_\_ and whomever he/she may designate as his/her assistant to examine, x-ray and administer chiropractic care as he/she deems necessary to my (child's name) \_\_\_\_\_, in my presence or absence.

(Son, daughter, other....)

(Childs Name) \_\_\_\_\_

Date: \_\_\_\_\_

(Parent or Guardian) \_\_\_\_\_

Date: \_\_\_\_\_

Witnesses: \_\_\_\_\_

Date: \_\_\_\_\_

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Date: \_\_\_\_\_

Dr. \_\_\_\_\_