WEBB CHIROPRACTIC CENTER
671 FIRST ST, SUITE. B
LINCOLN, CA 95648
916-434-0600

Consent to Treatment of Minor Child

I hereby authorize **WEBB CHIROPRACTIC CENTER** and whomever he may designate as his assistants to administer as he so deems necessary to my

Son/daughter (circle one), _____

(Minors name)

Parent/Guardian _____ Date _____

Witness: _____ Date _____