The Spine & Wellness Center of Exeter
Dr. Patrick Borja/Dr. Laura Edwards
Chiropractor

CONSENT TO TREAT A MINOR CHILD

I hereby authorize The Spine and Wellness Center to administer Chiropractic care, Acupuncture and or Massage Therapy as they deem necessary to my
_____(indicate relationship of child)

CHILD 'S NAME_____

DATE_____

PARENT'S NAME_____

PARENTS'S SIGNATURE_____

PARENT'S PHONE NUMBER_____

WITNESS_____

Period of treatment:_____