

# Anatomy Power Wellness Studio

## Consent to Treat a Minor

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Child's Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I am the parent of above child. I do hereby consent, authorize, and request the doctors at Anatomy Power Wellness Studio to administer chiropractic treatment(s) deemed advisable, necessary, and requested for the above named child.

I agree to hold Anatomy Power Wellness Studio and the doctors free and harmless from any claims or suits for any complications which may result from such treatment.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Parent or Guardian