ALEXANDER SPINE CENTER

CONSENT TO TREAT A MINOR

I hereby authorize Steven L. Goninan, D.C, and/or whomever he may designate, to examine and administer chiropractic care as he/she deems necessary to my child.

Full Name of child _____

Address: _____

Guardian's Name (Please Print) _____

Relationship to minor _____

Guardian's Signature_____Date_____

Witness _____

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