



# ALEXANDER CHIROPRACTIC CENTER

22930  
Three Notch Road  
California, MD  
20619

Ph: 301-737-4007  
FAX: 301-737-4003

14350  
Solomons Island  
Road, Suite 103A  
Solomons, MD  
20688

Ph: 410-394-1000  
FAX: 410-394-6800



## CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. \_\_\_\_\_

and/or his staff to examine and/or  
treat my daughter/son.

Full Name of Child \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signed \_\_\_\_\_

Dated \_\_\_\_\_

Witness \_\_\_\_\_

Dated \_\_\_\_\_