KAISER CHIROPRACTIC, S.C.
790 Gardner Street • Lake Geneva, WI 53147 *Christopher Kaiser, D.C.*

# CONSENT TO TREATMENT OF MINOR CHILD

Child's full name_____ Date of Birth_____

Mother's name_____ Phone: _____

Father's name_____ Phone: _____

I hereby authorize Kaiser Chiropractic, S.C. to provide chiropractic care and health services as deemed necessary to my child.

Signature_____Date_____

Printed name_____

(circle one: Mother/Father/Guardian)

If Guardian, your relationship to the patient_____