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# CONSENT FOR TREATMENT OF MINORS

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I (We) being parent, guardian or custodian of \_\_\_\_\_, a minor the age of \_\_\_\_\_, do hereby authorize, request and direct Dr. \_\_\_\_\_ to perform any exam, x-ray and QSM3 Upper Cervical chiropractic treatment for their condition as the Drs. deem necessary.

\_\_\_\_\_  
*Parent, Guardian or Custodian*

\_\_\_\_\_  
*Date*