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### Consent for Treatment of a Minor

I (We), being the parent(s) or custodian(s) of \_\_\_\_\_, a minor, the age of \_\_\_\_\_, do hereby authorize, request and direct Drs. Richard and Leanne Fink and Dr. David Harrigan to perform in their judgment all necessary treatment, including examination, x-rays and chiropractic adjustments of my (our) child.

\_\_\_\_\_  
Signature of Parent, Guardian or Custodian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian or Custodian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date