CONSENT TO TREAT A MINOR

(Parent/Guardian) Name____

Address: ________________________________City __________________

State ____ Zip ________

Home Phone: _____________________ Work Phone: ___________________

Name of Minor: ____

Sex: _________ Age: ______ Date of Birth: _____________________

I (we) being the parent/guardian of the above named minor, do hereby consent, authorize and request Dr. Ed Green, D. C., to administer such medical treatment as he deems necessary on the above named minor.

I (we) understand that Dr. Green's recommendations and instructions for care and treatment must be complied with, otherwise the doctor cannot be held responsible and/or liable.

I (we) understand that there will be certain recommendations and procedures to follow for the care of the above named minor. I (we) therefore agree to comply with the doctor's instructions for the total amount of care necessary until the doctor releases the patient.

Parent /Guardian Signature: Date

_____________________________________ _______________________