Rose City Chiropractic Clinic, P.C.
3292 N. M-33
P.O. BOX 27
ROSE CITY, MI 48654
989-685-2631

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize:

Dr. Kendall R. Paulson, Dr. Tabitha Frakes and whomever they may designate as assistants to administer chiropractic care, including x-rays and any therapies, as deemed necessary to:

My son / daughter / other relation (please circle one).

_____
(Name of Child)

Dated in ROSE CITY (City) MICHIGAN (State)

on this _____ day of _____, 2021.

Signed: _____

Witnessed: _____