Wolf
CHIROPRACTIC CLINIC
MASSAGE THERAPY & ACUPUNCTURE
15404 E Springfield Ave Suite 100
Spokane Valley, WA 99037
PH 509.892-9800
FAX 509.892-9998

CONSENT TO TREAT A MINOR

_____ _____
Child's Name Date of Birth

I hereby authorize □ Dr. Gina Wolf □ Dr. Lori Maupin
to administer chiropractic care as she deems necessary to the child listed above.

Dated _____

City_____ State _____

This _____ day of _____, _____
Day Month Year

Parent or Guardian Signature_____

Printed Name _____

Relationship to Patient _____