Ybor City
CHIROPRACTIC

1623 East 4th Avenue
Tampa, Florida 33605
813-238-2900

Consent to Treat a Minor

I, ____, hereby authorize Dr. Alex Lambert and whomever he may designate as his associate/assistant to administer treatment as he so deems necessary to my son/daughter/ward.

Name of Minor Child: ____

Signed at: ______________________________ (*City*), ______________________________ (*State*)

on the __________ (*Date*) day of ______________________________ (*Month*) 20 __________ (*year*)

Relationship to minor child: ____

Signature: ____ Date: ______________

Witness Signature: ____