

Patient name: \_\_\_\_\_ Pt ID #: \_\_\_\_\_



Physical Therapy • Athletic Training  
Massage • Acupuncture • Dry Needling

## CONSENT TO TREAT A MINOR

I hereby authorize, Iselborn Chiropractic and Physical Therapy, and whomever the treating physicians may designate as assistant(s) to administer treatment(s) as she deems necessary to my child, \_\_\_\_\_.

Patients Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Date