CONSENT TO TREATMENT OF A MINOR CHILD

I, being the parent or legal guardian, hereby authorize Dr. _____

and whomever he/she may designate as assistants to administer treatment as deemed necessary to

_____

Name of Minor

Dated at _____ this _____ day of _____, _____

Timothy P. Angelo, D.C. C.C.E.P.
Sophia Suprai D.C.
NorCal Spine & Sport
903 Embarcadero Drive, Suite 4
El Dorado Hills, CA 95762
P: (916) 933-9870 • F: (916) 933-3540

_____ _____

Signature of Parent or Legal Guardian **Date**

_____ _____

Printed Name of Parent or Legal Guardian **Date**

_____

Relationship to Patient

_____ _____

Witnessed by **Date**