Dr. Kristine B. Simonson D.C.
Metro Chiropractic Center
701 N. 132 St.
Omaha, NE 68154
(402) 496-6090

CONSENT TO TREAT A MINOR

I hereby authorize *Dr. Kristine B. Simonson* and whomever she may designate as assistants to administer chiropractic care as deemed necessary to my

______________________________, ____.
(relationship of child) (name of child)

Date: ______-______-20____

Signed: ____
(parent or guardian)

Witnessed: ____