Mark Eiler, D.C. ; Justin Eiler, D.C. ; Andrea Eiler, D.C.
Oakview Medical Building Suite 230

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Mark Eiler, D.C.; Justin Eiler, D.C.; Andrea Eiler, D.C. and whomever he/she may designate as his/her assistants to administer treatment and any necessary x-rays as he/she so deems necessary to my son/daughter, _____.

Name (printed): _____

Signature: _____

Relationship to child: _____

Dated: _____

Witness: _____