DONALD K SHIFLET, DC
CHIROPRACTIC PHYSICIAN

CONSENT TO TREATMENT OF A MINOR

I, _____, hereby authorize The Back Alley Chiropractic clinic/doctor/assistants to administer chiropractic treatment as deemed necessary to my son/daughter/legal dependent _____.

This authorization shall remain effective until _____ / _____ / _____, unless sooner revoked in writing.

Parent/Guardian Signature _____ Date _____

2060 E Tangerine Rd #182, Oro Valley AZ 85755 **PHONE** (520) 877-2666 **FAX** (520) 877-9183