ADAMS
CHIROPRACTIC INC. P.S.

Authorization To Care For a Minor Child

I hereby authorize Dr. Kurt M. Adams and his massage therapy staff to work with my child (name) _____ through the use of adjustments and procedures to the spine, as the Doctor deems appropriate.

_____ _____

Patient's Name (Print) Parent or Legal Guardian's Name (Print)

_____ _____ _____

Parent or Legal Guardian Signature Date Witness

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