

# CONSENT TO TREATMENT OF MINOR CHILD

I, \_\_\_\_\_, hereby authorize  
(parent or legal guardian's name)

**Dr. Jack Giangliulo, D.C.** and whomever he may designate as assistants to administer treatment  
as deemed necessary to \_\_\_\_\_.  
(minor's name)

\_\_\_\_\_  
(parent or legal guardian's signature)

\_\_\_\_\_  
(date of signature)

\_\_\_\_\_  
(relationship to patient)

Witnessed By: \_\_\_\_\_