



Consent for Treatment of a Minor

I (we) being the parent(s), guardian(s) or custodian(s) of _____
a minor, the age of _____, do hereby authorize request and direct Dr. Albert G.
Simoncelli, D.C. to perform in his judgement any necessary examination, x-ray,
and chiropractic treatment for the condition.

Parent, Guardian or Custodian

Dated

Parent, Guardian or Custodian

Dated

Witness

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Fax: 256-2206

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