

**Back to Health Family Chiropractic
Dr. Molly Keefe
128 North Main Street
St Albans, Vermont 05478
(802) 527-BACK**

CONSENT TO TREATMENT OF A MINOR

I hereby authorize BACK TO HEALTH FAMILY CHIROPRACTIC to evaluate and treat, as they deem necessary, my **daughter/son**(circle one), _____(child's name).

I further attest that I have the legal ability to make medical decisions on my child's behalf.

Date: _____

Signed: _____

Witness: _____

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