CONSENT TO TREATMENT OF MINOR CHILD

I, _____, hereby authorize David C. Creech, D.C. and whomever he any designates as his assistants to administer treatment as he deems necessary to my _____,

(Son / Daughter, etc.) (Patient's Name)

Signed:

Relationship to patient:

Date:

Witness:

Apex Medical Park, 800 W. Williams St., Suite 201, Apex, NC 27502 HYPERLINK "http://www.creechchiropractic.com" (919) 367-2828 www.creechchiropractic.com Fax (919) 367-2822