



## Team Lopez Chiropractic

### CONSENT FOR TREATMENT OF A MINOR

I (we) being the parent/s, guardian or custodian of \_\_\_\_\_  
a minor at the age of \_\_\_\_\_, do authorize, request and direct  
Dr. Nasly M. Lopez or Dr. Francisco Lopez to perform in their judgment  
any necessary examination, x-ray and chiropractic treatment for the  
condition.

\_\_\_\_\_  
**Parent, Guardian or Custodian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent, Guardian or Custodian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**