



472 W. Main Street • Gallatin, TN 37066 • (615) 451-4306 • Fax (615) 451-2634

CONSENT TO TREAT A MINOR CHILD

I hereby authorize Dr. Scott Schroeder and whomever he may designate as assistants to administer chiropractic care as deemed necessary to

Name of Child

Signed: _____ Date: _____

Relationship to Child: _____

Witness: _____