

**WESTWOOD CHIROPRACTIC S.C.
7639 W. BELOIT ROAD
WEST ALLIS, WI 53219
414-543-1951 FAX 414-543-1595
DR. MICHELLE DRAGGOO**

CONSENT TO TREAT OF A MINOR CHILD

I hereby request and authorize Dr. Michelle Draggoo at Westwood Chiropractic S.C. and whomever he/she may designate as assistants to administer diagnostic tests, chiropractic adjustments and other treatment deemed necessary to _____, my son/daughter. This authorization is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office

Date: _____

Signature _____

Witness _____

Relationship to Patient: _____