

Offices of Dr. Jack R. Giangiulio, DC

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CONSENT TO TREATMENT OF MINOR CHILD

I, _____, hereby authorize
(parent or legal guardian's name)

Dr. Jack Giangiulio, D.C. and whomever he may designate as assistants to administer treatment

as deemed necessary to _____.
(minor's name)

(parent or legal guardian's signature)

(date of signature)

(relationship to patient)

Witnessed By: _____