



13708 MADISON AVENUE
LAKEWOOD, OHIO 44107
216.221.2008 • FAX 216.221.6446
www.gentnerchiro.com

Consent to treatment of minor child.

The parent or guardian of _____ . I (we)
give you permission to treat my (our) child at your office.

Parents or guardian name(s) _____
(Please print)

Address _____

Contact Phone _____ or _____

Signature of parent or guardian _____

Date _____ / _____

Witness _____
(Office Staff)