ELITE
WELLNESS

CONSENT FOR TREATMENT OF MINOR

Date: _____

I hereby authorize: Dr. Ben Duke and whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

_____
Minor Patient's Name

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date

Parent Remarks: _____

_____

_____

_____

Plaza del Lago
Arcade Unit 20-21
1515 Sheridan Road
Wilmette, IL 60091

office: 847.920.4544
fax: 847.920.5754

www.LiveElite.com