CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Gary L. Willis and whomever

he may designate as his assistant to administer

treatment as he so deems necessary to

my _____, _____.
(relationship) (name)

Dated at WILLIS CHIROPRACTIC CENTER, 317 N. Main St., Alpharetta, GA 30009

This_____ day of _____, 20____.

Signed: _____

Witnessed: _____