CONSENT TO TREATMENT OF A MINOR CHILD
ROOTS WELLCARE, P.A.

To be completed if patient is under age 18

Patient Name (minor) ____

Parent or Guardian Name ____

I, (parent, guardian), ____, give Dr. Carla Breunig permission to examine and treat (minor child) ___________________________.

____ ___________________________
Signature of Parent or Guardian Date

____ ___________________________
Carla Breunig, D.C. (witness) Date