WELLESLEY CHIROPRACTIC OFFICE
Martin G. Rosen, D.C. Nancy J. Watson, D.C

AUTHORIZATION FOR CARE OF A MINOR

Name of Minor (First, Middle, Last) _____

I hereby authorize Dr. Martin G. Rosen and whomever he may designate as his assistants to administer chiropractic care to my daughter/son/ward.

Signature _____ Date _____

Print Name _____

Relationship to minor patient (CIRCLE ONE): PARENT GUARDIAN

471 Washington Street • Wellesley • Massachusetts • 02482-5935
Telephone (781) 237-6673 Fax (508) 651-2209