

DR. TREVOR O. ERIKSEN, B.A., D.C.
4600 Kietzke Lane, Bldg E, Suite 145

Reno, NV 89502

(775) 772-7961

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Trevor Eriksen and whomever he may designate as his
assistant(s) to administer treatment as he so deems necessary to

_____, my son / daughter.

Signature of Parent or Guardian

Date: _____

Printed Name