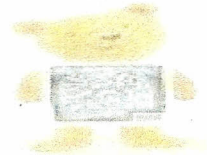
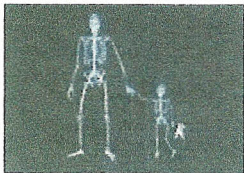


Family Healthcare Clinic, Inc.

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Dr. Deborah M. Brown

Consent for Treatment of a Minor

I (we) being the parent(s), legal guardian or custodian(s) of

_____, a minor, the age of _____, do hereby
authorize, request, and direct Dr. Deborah M. Brown, and/or assigns, to perform, in her
judgment, any and all necessary examinations, x-rays, and/or chiropractic treatment(s).

Please print minor patient's name

Please print parent/guardian's name

Signature of parent/ guardian

Date

Remarks:
