



14201 Metcalf Ave. Overland Park, KS 66223 (913) 814-9494 www.LionsGateChiro.com

CONSENT TO TREAT A MINOR CHILD

I, (*Parent/Guardian*) _____ am the parent/legal guardian of (*Minor*) _____. I hereby authorize *Brooke Northern L.M.T* and whomever she may designate as her assistants to administer massage therapy as she deems necessary to my minor child. I acknowledge that I am fully informed about the risks and benefits.

Patient Name: (*print*) _____ Date: _____

Signature: (*parent or guardian*) _____