Living Well Holistic Health, LLC

CONSENT TO TREAT A MINOR

NAME: _____

ADDR: _____

CITY: _____ ST _____ ZIP _____

PHONE: _____ SS# _____

I HEREBY AUTHORIZE:

Dr. Alyssa Guglielmo or any doctors associated with the above named practice,

to administer the required care as deemed necessary to

my (indicate relationship of child) _____

(Name of Child) _____

SIGNED: _____

WITNESSED: _____