As a parent or guardian of ____,

I authorize DR. CHARLES F. ROOST to administer Chiropractic treatment to my

______________________ (specify relationship).

____

Signature of Parent or Guardian Date

As a parent or guardian of ____,

I authorize **DR. DANIEL D. DAIL** to administer Chiropractic treatment to my

______________________ (specify relationship).

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Signature of Parent or Guardian Date