325 FOURTH STREET
MARIETTA, OHIO 45750

P :: 740 . 376 . 9944
E :: info@mymariettahealth.com

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Jeffrey R. Dexter, DC, and/or his staff to examine and/or treat my daughter/son.

____

Full Name of Child (please print)

____

Address

______________	______________	______________
City	*State*	*Zip Code*

____

Phone number

SIGNED

______________	______________	______________
Name of parent or legal guardian (please print)	*Signature of parent or legal guardian*	*Date*

WITNESS

______________	______________	______________
Name (please print)	*Signature*	*Date*