



**MUNROE CHIROPRACTIC, P.C.**  
6035 Main St. Williamsville, NY 14221  
716-632-4476 or 63-CHIRO  
(Fax: 716-632-4503)

**CONSENT TO TREAT A MINOR CHILD**

I hereby authorize Dr. Kenneth Munroe, Dr. Aaron Mierzwa,  
Dr. Matthew Millanti, Dr. Safeya Muhammad and Dr. Danielle  
Walsh to administer chiropractic care as deemed necessary.

To my \_\_\_\_\_ (indicate relationship of child)

Name of child: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Witnessed by: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_