Parent/Guardian Consent for Care

I hereby authorize *Dr. Kenneth Miller Jr.* and/or *Dr. Caleb Miller* and whomever he may designate as his assistants, to administer chiropractic care as he deems necessary to my child.

Child's name: _____

Parent/Guardian Signature: _____

Date: _____

692 Portland Way North
Galion, OH 44833
419-393-9037

1670 E. Mansfield Street
Bucyrus, OH 44820
419-562-4300