

Dr Judith Boothby MS DC PC

**1620 SE Ankeny
Portland, Oregon 97214
(503) 233-0943**

CONSENT FOR TREATMENT OF MINOR

I, _____
(please type or print name)

Give my consent for examination and treatment of:

Name _____ DOB _____

by Dr JUDITH BOOTHBY DC

Signature _____ Date _____

Relationship _____