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**CONSENT TO TREAT MINOR CHILDREN**

I do hereby consent to any medical care determined by a physician to be necessary for the

welfare of my child while said child is under the care of Bluffs Physical Therapy LLC.

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**Name of Minor Date of Birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent or Legal Guardian Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Witness Name (please print)