BODY ZONE™
PHYSICAL THERAPY

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PERMISSION TO TREAT A MINOR

DATE: _____

MINOR'S NAME: _____

DATE OF BIRTH: _____

I (Parent / Legal Guardian) grant permission and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the Therapist/Therapist Assistant at Body Zone Physical Therapy.

This form is valid for one year from the date which it is signed.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

_____

PRINT PARENT/LEGAL GUARDIAN NAME