## **PERMISSION TO TREAT A MINOR**

who is a minor under the age of 18 for the sole purpose of evaluation and or treatment of injuries sustained while participating in school sports.  I also understand that Dr. Cruz is offering his services while on the field free of charge.  I have read and understand the above. ( <i>Parent or guardian sign</i> )  Name (Please Print):	I GIVE PERMISSION FOR Miguel Cruz DC, a licensed of	loctor of chiropractic in the
I also understand that Dr. Cruz is offering his services while on the field free of charge.  I have read and understand the above. ( <i>Parent or guardian sign</i> )  Name (Please Print): Date:	state of North Carolina to treat/examine	
I also understand that Dr. Cruz is offering his services while on the field free of charge.  I have read and understand the above. ( <i>Parent or guardian sign</i> )  Name (Please Print): Date:	who is a minor under the age of 18 for the sole purpose of evaluation and or	
I have read and understand the above. ( <i>Parent or guardian sign</i> )  Name (Please Print): Date:	treatment of injuries sustained while participating in so	chool sports.
Name (Please Print): Date:		while on the field free of
	I have read and understand the above. (Parent or gua	ardian sign)
Signature:	Name (Please Print):	Date:
	Signature:	