Well Being Health Center

19045 State Hwy 305, Suite 190 · Poulsbo, WA 98370
Tel: (360) 697-6100 Fax: (360) 697-4500

Consent to Treat a Minor Child

I hereby authorize _____ and whomever he/she designates as his/her assistant(s), associate(s) and/or consultants to administer any treatment as he/she deems necessary including radiographic and/or other studies to my:

(Son) _____ Date of Birth: _____

(Daughter) _____ Date of Birth: _____

Signed and Dated at:

Well Being Health Center
19045 State Hwy 305, Suite 190
Poulsbo, WA 98370

Guardian Signature: _____ Date: _____

Witness: _____