



Cunningham Chiropractic PC
Dr. George T. Cunningham DC
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I _____ (Parent or Guardian's Name), Authorize the performance of Chiropractic diagnostic and therapeutic procedures for _____ (Patient's Name), to be performed by Dr. George T. Cunningham and his staff. I consent to the performance of those procedures that they consider are necessary or advisable in the course of _____ (Patient or Guardian's Name), health care.

Signed: _____ (Parent or Guardian's Name)

Date: _____

Witness: _____

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