

**Robert Jusino, D.C., M.P.H.**

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(708) 771-0665

**TREATMENT CONSENT**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I \_\_\_\_\_ hereby authorize Dr. Robert Jusino to  
examine and treat my son/ daughter \_\_\_\_\_, a  
minor.

Parent's signature: \_\_\_\_\_