Dr. Zar
Naturopathic Doctor

Consent to treat a Minor

Date: _____/_____/_____
day month year

Patient Name: _____

File #: _____

Date of Birth: _____/_____/_____
day month year

As guardian of the above named patient, I give my consent to his/her treatment by the following:

□ Naturopath - Dr. Zarlashta Popal

Please check one: □ Legal Guardian □ Mother □ Father

Print Name: _____

Signature: _____