

Dr. Scott Jurica, MS, DC, PAK, ACN  
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I \_\_\_\_\_ hereby authorize Dr. Scott Jurica, MS, DC.PAK, ACN to examine and treat my child's condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures and therapies to be performed.

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_