

PLATTE VALLEY   
**Chiropractic**  
ACUPUNCTURE & WELLNESS CENTER

DR. SCOTT A. SOLE, D.C., D.A.B.C.I.  
DR. TRENTON L. TALBITZER D.C., MS

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**Minor Consent Form**

I, \_\_\_\_\_ give Dr. Scott A. Sole, DC, DABCI

OR

Platte Valley Chiropractic Acupuncture & Wellness Center, consent to treat my  
minor dependent

\_\_\_\_\_  
(Minor's Name & Date of Birth)

\_\_\_\_\_  
(Parent or Legal Guardian Signature)

\_\_\_\_\_  
(Date)