**** 3050 W 151St Ct.

Suite 100

Broomfield, CO 80023

www.aboundinghope.life

(303) 494-3116 Office

**Child/Guardian Permission Form**

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

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do hereby give permission for my child who is under the age of 18 to be seen by Kerry Sprague and Abounding Hope Health Options LLC in order to identify the location for SAAT allergy treatment. I also give permission for my child who is under 18 to be treated by independent licensed acupuncturist Anita Curry, MSLAc, LMT, CD(DONA).

I give my permission for my child who is under 18 to be seen with or without my presence in the office. I will and do assume all responsibility for my child and understand that he/she may be brought by a child care provider or drive themselves and may receive treatment deemed necessary by Kerry Sprague and Abounding Hope Health Options LLC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature