Welcome To
Kennesaw Pediatrics
Your Home for Pediatric Healthcare!

770 - 429-1005 - Phone
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3745 Cherokee Street Suite 401 - Kennesaw GA 30144
Authorization Medical Treatment

AUTHORIZATION FOR MEDICAL TREATMENT IN THE ABSENCE OF LEGAL GUARDIAN

PATIENT(S) NAME (S): _____ **DOB:** _____

I am aware that my child may require medical treatment when I am not able to be present. In my absence, I give to:

Individual's Names	Relationship

my permission to authorize any and all medical treatment(s) for my child named above.

AND

In my absence, I give permission to KENNESAW PEDIATRICS, PC and all its staff to examine and provide emergency treatment to my child, _____.
In addition, the physicians/clinic have my permission to refer my child's emergent care and treatment to the appropriate service physician/hospital/lab/urgent care or medical facility to provide optimal care for the treatment of illness or injury. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child's care.

This authorization becomes affective on _____ and ends _____
DATE **DATE OR "NEVER"**

_____ _____ _____
Parent/Legal Representative SIGNATURE **Relationship to Patient** **DATE**