Last updated March 2024

McDonough Pediatrics, P.C.

101 Regency Park Drive, Ste 140
McDonough. GA. 30253

PERMISSION TO TREAT CHILD IN PARENTS ABSENCE

I, ___________________________, give permission to the names listed below to bring my
(PARENT'S NAME)

child, ________________________, in for medical treatment. I understand the purpose for disclosing personal
(CHILD'S NAME) (DOB)
health information to the person noted below. I also understand that I can refuse to sign this consent form.

Mother's full name: ____

Father's full name: ____

Individuals Name: ____

Relation: ____

Phone Number: ____

Individuals Name: ____

Relation: ____

Phone Number: ____

Individuals Name: ____

Relation: ____

Phone Number: ____

Individuals Name: ____

Relation: ____

Phone Number: ____

Individuals Name: ____

Relation: ____

Phone Number: ____

Parent Signature: ____ **Date:** ________________________

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