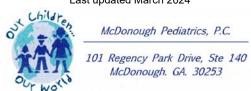
Last updated March 2024



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) (D	OB) erson noted below. I also understand that I can refuse to sign this consent form.
nearm information to the pe	erson 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:

Office: 770-957-8626 | Fax: 770-957-7200