Kids First Pediatrics of Georgia
Pediatric Consent Form (In the Absence of the Parent of Guardian)

Patient Name: _____ DOB_____

I (We) the parent (s) or legal guardian (s) authorize the individual (s) named below to act in my (our) behalf with the full authority to grant permission for any medical treatment or surgical procedure that is in the best interest of the above named child in the opinion of the Kids First Pediatrics of GA physicians. This also authorizes physicians to discuss confidential health information concerning the patient with the individuals who are authorized to bring the patient into the office for medical treatment. I understand that the physician may request to contact the parent/ guardian prior to providing medical treatment even though this consent is presented. I understand that as parent(s) or legal guardian(s) that I am financially responsible for all care received as a result of this consent. ADULTS THAT MAY CONSENT FOR MEDICAL TREATMENT IN MY (OUR) ABSENCE: (Authorized individuals should also be listed in Privacy Practices)

Name: _____
Phone #: _____Relationship to Patient_____

Name: _____
Phone #: _____Relationship to Patient_____

Name: _____
Phone #: _____Relationship to Patient_____

Name: _____
Phone #: _____Relationship to Patient_____

Name: _____
Phone #: _____Relationship to Patient_____

This consent form will be in effect for 12 months from signing or less time if specified. AUTHORIZED BY: (Both parents signature preferred, but not required) By signing below, I certify that I am the legal parent or guardian of the child identified above and that I am acting within my authority in signing this Pediatric Consent form.

Mother (Printed): _____ Signature_____
Date_____
Father (Printed)_____ Signature_____ Date _____
Legal guardian (if not father or mother)(printed)_____
Signature_____ Date_____

ANY CHANGES TO THIS CONSENT MUST BE MADE IN PERSON AT ONE OF THE KIDS FIRST PEDIATRICS OF GA LOCATIONS.