UNITED PEDIATRICS, PC
4775 JIMMY CARTER BLVD. #102
NORCROSS, GA 30093
770-717-0033

AUTHORIZATION FOR MEDICAL TREATMENT OF A CHILD IN THE ABSENCE OF PARENT OF LEGAL GUARDIAN

CHILD'S NAME_____ DATE OF BIRTH _____

AUTHORIZATION GIVEN TO:

1. ADULT'S NAME: _____RELATION TO CHILD _____

2. ADULT'S NAME: _____ RELATION TO CHILD_____

I, the undersigned parent or legal guardian of the above named child, gives permission to the adult(s) named above to act on my behalf to obtain medical care and treatment for **SICK VISIT ONLY** needed for my child as deemed advisable by Dr. Tayaba Fatema.

Parent of Legal Guardian (print): _____

Parent of Legal Guardian (signature): _____

Relationship to Child: _____ Date: _____