JONESBORO PEDIATRICS

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Authorization for Medical Treatment in the Absence of Legal Guardian

Your Children's Names:

Full Name:_____ DOB:_____ [ ]M [ ]F
Full Name:_____ DOB:_____ [ ]M [ ]F
Full Name:_____ DOB:_____ [ ]M [ ]F
Full Name:_____ DOB:_____ [ ]M [ ]F
Full Name:_____ DOB:_____ [ ]M [ ]F

I am aware that my child may require medical treatment when I am not able to be present. In my absence, I give the individual(s) listed below my permission to authorize any and all medical treatment for my child(ren) named above.

Individual's Full Name	Relationship to Patient

Furthermore, in my absence, I give permission to Jonesboro Pediatrics and its entire staff to examine and provide emergency treatment to my child(ren). In addition, the physicians/clinic has 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(ren)'s care whether or not services are covered by insurance.

This authorization becomes effective on_____and ends on_____.
Date Date or "Never"

_____ _____ _____
Parent/Legal Guardian Signature Relationship to Patient Date