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Statesboro, GA 30458
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CONSENT FOR TREATMENT

Date:______________________________

Patient Name: ____________________________________ DOB: _________________________

Patient Name: ____________________________________ DOB: _________________________

Patient Name: ____________________________________ DOB: _________________________

Patient Name: ____________________________________ DOB:__________________________

I, ___________________________________, give permission to the following individuals to make medical decisions on my behalf and/or in my absence for the child(ren) listed above. The individuals listed below are able to (select all that apply):

- ☐ **SPEAK WITH THE TRIAGE NURSE OVER THE PHONE**
- ☐ **BRING MY CHILD(REN) TO APPOINTMENTS**
- ☐ **RETRIEVE LAB OR XRAY RESULTS VIA PHONE OR IN PERSON**

____ _____________________________
Name **Relationship**

____ _____________________________
Name **Relationship**

____ _____________________________
Name **Relationship**

____________________________________ ___________________________________
Parent Name Printed **Parent Signature**