1045 Southcrest Drive, Suite 110
Stockbridge, GA 30281
Phone: (770)-507-2212

CONSENT FOR TREATMENT

I do, hereby, voluntarily request medical care and/or services at Kids First Pediatric Group, LLC for my child/children as listed on my application for registration. I hereby authorize and grant my permission and consent for all providers employed by Kids First Pediatric Group, LLC to use such diagnostic and treatment procedures as they deem necessary for proper medical management and treatment of my child/children, and I hereby release Kids First Pediatric Group, LLC and its medical staff and employees from any liability for the results of such procedures. I fully understand that no guarantee or warranty of results that may be obtained has been given or implied by the physicians or medical staff employees of Kids First Pediatric Group, LLC, or is in any way intended hereby. I also acknowledge that I may, at any time, refuse to accept medical care or services for my child/children and I accept full responsibility for said act or statement of refusal.

I further understated that on-site services are not provided by Kids First Pediatric Group, LLC on nights, weekends and announced holidays. If treatment is needed, Kids First Pediatric Group, LLC is unable to provide off-site services, I will seek such treatment at the hospital providing, Emergency Services for that particular day or night.

I acknowledge the right of Kids First Pediatric Group, LLC, and/or its agents, for due and proper cause, to refuse to initiate or continue medical care services for my child/children.

I certify that I am legally entitled to sign this statement of permission for treatment. By signing below, I acknowledge that I understand the above.

Patient Name and Date of Birth:_____________________ MRN: ___________

Parent/Legal Guardian Signature: ___________________________________ Date _________________

Witness: ____ Date _________________

This treatment includes all, but not limited to, the immunizations listed below:

DTAP, IPV, MMR, TB, PPD, HIB, MCV, Pediatrix, TD, PCV, VARIVAX, HPV, Influenza

I, _______________________, authorize the following person(s) to accompany ______________________
(Name of parent or legal guardian) (Name of child/children)
for treatment:

_______________________________________ Relationship to child: ____________________________
_______________________________________ Relationship to child: ____________________________
_______________________________________ Relationship to child: ____________________________

Signature of Parent or Legal Guardian ______________________________ Date___________________________