



300 Dawson Commons Circle, Suite 320 · Dawsonville, GA 30534
Tel: (706) 216-2771 · Fax: (706) 216-2944

AUTHORIZATION TO BRING CHILD

Child's Name: _____ Date of Birth: _____

We (I) hereby authorize the physicians at Dawson Pediatrics, in our (my) absence, to provide required medical treatment, in the opinion of the provider for our child and we (I) authorize the following person(s) to give permission for medical treatment for the above named child.

Name	Relationship to Patient	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** Please note, we will ask for identification from the person(s) listed above ***

Parent / Legal Guardian: _____
Print Name

Parent / Legal Guardian: _____ Date: _____
Signature

Carmina F. Babao, MD, FAAP · Honorio R. Bulos, MD, FAAP · Joanna B. Morris, MD, FAAP
Debra Flax, CPNP · Peggy Booher, CPNP

Rev. Mar-10