THE KIDSMD
Douglas Marira, MD, MA, MPH
304 Stephenson Avenue
Savannah, GA 31405
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Pediatrician Board Certified by the
American Board of Disability Analysts

_____
DATE

Parental Consent for Medical Treatment

Child's Information:

Child's Name: _____ Date of Birth _____

Home Address _____

Home Address _____ Home Phone _____
CITY STATE ZIP CODE

Parent or Legal Guardian _____ Home Phone _____

Caregiver Information:

Caregiver Name: _____ Home Phone _____

Caregiver Name: _____ Home Phone _____

Caregiver Name: _____ Home Phone _____

Above the named caregiver, or individual shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, immunizations, diagnostic tests, etc.), for the above named child, which may be required during my absence.

This consent serves as permission for treatment by Dr. Marira and staff of THE KIDS MD. I agree to pay for all services provided to my child, including services provided in my absence. This authorization shall be effective until (select one):

○ A: _____ /_____ /_____ (Month/Day/Year)
○ B. Unless earlier revoked by me in writing.

Signatures:

Parent/Guardian (Circle One) _____ Date _____

Parent/Guardian (Circle One) _____ Date _____

Witness _____ Date _____

By signing this document, I hereby knowledge that I have received a copy of THE KIDS MD joint notice of privacy rights.

Parent Signature _____ Date _____

Please Print Name _____

Reason acknowledgment was not obtained: _____

Witness _____ Date _____

Witness _____ Date _____