KIDS FIRST PEDISTRIC GROUP, LLC

CONSENT FOR TREATMENT

1045 Southcrest Drive, Suite 110
Stockbridge, Georgia 30281
770-507-2212

I do herby voluntarily request medical care 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 it's 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, LC on nights, weekends and announced holidays, that if treatment is needed, and 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 Firs 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.

Requestor's Signature _____ Date _____
(I understand the above)

Witness _____ Date _____

I, _____, authorize the following persons to bring _____
(Name of parent or legal guardian) (Name of child/children)

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

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

_____ Relationship to child _____
_____ Relationship to child _____
_____ Relationship to child _____
_____ Relationship to child _____
_____ Relationship to child _____

Signature of Parent or Legal Guardian _____ Date_____