

PERMISSION TO TREAT

THE FOLLOWING PEOPLE HAVE MY PERMISSION TO HAVE MY CHILD,
_____, TREATED AT ATHENS WOMEN'S AND
CHILDREN'S CENTER FOR ANY MEDICAL CONDITION IN THE EVENT THAT I CANNOT
ATTEND THE APPOINTMENT:

1. NAME: _____
RELATIONSHIP TO CHILD: _____
PHONE # _____
2. NAME: _____
RELATIONSHIP TO CHILD: _____
PHONE # _____
3. NAME: _____
RELATIONSHIP TO CHILD: _____
PHONE # _____
4. NAME: _____
RELATIONSHIP TO CHILD: _____
PHONE # _____
5. NAME: _____
RELATIONSHIP TO CHILD: _____
PHONE # _____

SIGNATURE OF PARENT/GUARDIAN

DATE