PEDIATRIC
ASSOCIATES OF SAVANNAH

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1001 Memorial Lane, Savannah, GA 31410

Patient: DOB: / / Date: / /

To Whom It May Concern,
the following people have my permission to obtain medical care for my children:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

In my absence, the physicians of Pediatric Associates of Savannah, PC may discuss his/her medical situation with this designated person. I will be responsible for all expenses incurred for this treatment.

Sincerely,

_____

Parent or Legal Guardian of

Child's Name	Date of Birth	Child's Name	Date of Birth
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____