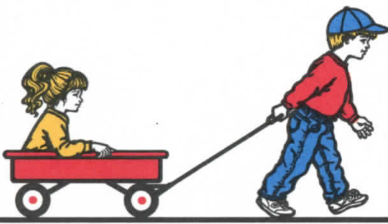

Pediatric Associates of Johns Creek, P.C.

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AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

Patient's Name: ______________________________ DOB: ____________
Patient's Name: ______________________________ DOB: ____________
Patient's Name: ______________________________ DOB: ____________
Patient's Name: ______________________________ DOB: ____________
Patient's Name: ______________________________ DOB: ____________
Patient's Name: ______________________________ DOB: ____________

As the parent/legal guardian of the above listed children, I do hereby grant the following individuals the authority to seek medical care and treatment for said children from Pediatric Associates of Johns Creek in the event of my absence.

Authorized Individual: ______________________________
DOB: ____________ Relation to Patient: ____________________

Authorized Individual: ______________________________
DOB: ____________ Relation to Patient: ____________________

This grant of temporary authority shall begin on ______________(date), and shall remain in effect until terminated by myself. I understand that Pediatric Associates of Johns Creek recommends a parent/legal guardian be present for all wellness exams, as immunizations may be needed. IMMUNIZATIONS WILL NOT BE ADMINISTERED WITHOUT A PARENT OR GUARDIAN PRESENT.

In the case of an emergency, the care provider should contact the following individual:

Name: ______________________________ Relationship to Patient: ____________
Cell Phone #: ______________________ Alternate Phone #: ________________

Signed: ______________________________ ______________________________
(print parent/legal guardian name) (parent/legal guardian signature)

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www.pedsmd4kids.com