Pediatric Associates of Johns Creek, PC

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Medical Treatment Authorization for a Minor

I, the undersigned parent/guardian of _____ (child's name), hereby grant Pediatric Associates of Johns Creek, PC authority to provide medical treatment in my absence.

Pediatric Associates of Johns Creek, PC recommends a parent/guardian be present for wellness exams, as immunizations may be needed. Immunizations will not be administered without a parent/guardian present.

This grant of temporary authority shall begin on _____, and shall remain effective until terminated by the undersigned.

In case of emergency, the care provider shall contact the following person(s) in the order listed below:

Name_____ Relationship_____
Preferred Phone Number:_____
Alternate Phone Number:_____

Name_____ Relationship_____
Preferred Phone Number:_____
Alternate Phone Number:_____

_____ _____
Parent/Guardian Signature Parent/Guardian Printed Name

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