



**Johns Creek Pediatrics  
Consent to Treat Authorization**

I hereby give authorization to the following named individuals to accompany my child/children for treatment at Johns Creek Pediatrics, PC:

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This includes, but is not limited to, medical evaluation, treatment and administering of immunizations.

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Child's Name	Date of Birth
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Child's Name	Date of Birth
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Child's Name	Date of Birth
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Parent Signature	Date