Creekview Pediatrics

caring For your child From birth to 21 yrs

Emory Johns Creek Hospital Physicians Plaza
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Johns Creek, GA 30097

Phone: (770)-622-7742
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Consent For Non-Urgent Pediatric Care

Child's Name _____ Date of Birth_____

Child's Name _____ Date of Birth_____

Child's Name _____ Date of Birth_____

Child's Name _____ Date of Birth_____

Authorized Caregiver's Information (*person other than Mom/Dad*)

_____	_____	_____
Caregiver's Name	Phone Number	Relationship
_____	_____	_____
Caregiver's Name	Phone Number	Relationship
_____	_____	_____
Caregiver's Name	Phone Number	Relationship

The above named caregiver(s) shall be authorized to consent for all medical treatment for the above named child(ren), which may be required during my absence. Caregiver will be required to present valid picture identification. I agree to be financially responsible for all services provided to my child(ren) authorized by caregiver(s).

I understand that written consent for immunizations will be required from parent(s) or legal guardian. If circumstances permit and/or if Creekview Pediatrics needs to speak with me, please contact me at the following telephone number:_____.

This consent serves as permission for treatment for the above named child(ren) by Creekview Pediatrics . **This authorization shall be in effect until** _____ .
Month Day Year

This authorization will remain in effect until the date stated above- unless I revoke this authorization in writing and submit it to Creekview Pediatrics prior to this date.

Signature

_____ _____
Parent/Legal Guardian (circle one) Date

_____ _____
Witness Date