



**2964 North State Road 7
Suite 340
Margate, FL 33063**

Phone: 954-974-3006

Fax: 954-974-8921

**Mary Ellen Zondorak-Perez, M.D., F.A.A.P.
Francine B. Magaletti, M.D., F.A.A.P.
Nadia Levinson, M.D., F.A.A.P.**

Consent to Treat

_____ & _____ authorize
(Mother's Name) (Father's Name)

Personal Care Pediatrics and its personnel to deliver medical services to my child(ren), listed below:
Please Print

Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____

I (We) authorize the following people to bring my child(ren) in for treatment, and/or to contact in case of emergency:

Name: _____	Relationship to child: _____
Name: _____	Relationship to child: _____
Name: _____	Relationship to child: _____

Parent Name _____ Signature: _____

Each individual must bring in a valid photo ID so we may properly identify them.
Please keep in mind this is for your family's own safety.

Revised 2014