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Consent for Medical Treatment

_____ & _____ authorize
(Mother's Name or Legal Guardian) (Father's Name or Legal Guardian)

Please list the best number to reach you in case we need to contact you for any reason:

Phone #: _____ Phone #: _____
Mother/Legal Guardian Father/Legal Guardian

I allow 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: _____

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

Parent Name _____ Signature: _____ Date: _____

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.