BOCA PEDIATRIC GROUP
5458 Town Center Road #20
Boca Raton, FL 33486
Phone 561-391-6210 ~ Fax 561-391-2810

General Consent for Treatment

Patient Name_____ DOB_____
Patient Name_____ DOB_____
Patient Name_____ DOB_____

As the legal parent/guardian of the child(ren) listed above, I understand that this form is my/our written consent and authorization allowing any and all physicians working for or on behalf of Boca Pediatric Group to conduct any medical treatment (including immunizations, medications, diagnostic tests, etc) necessary to effectively access and maintain my/our child's health and to access, diagnose and treat my/our child's illness or injury.

In the event of the necessity for emergency treatment, I/We give you my/our consent to make any selection and assignment of any other physician, surgeon or other specialist which you deem necessary to assist in the treatment of my child and agree to be responsible and pay for any services rendered. I/We accept any such emergency treatment with the understanding that no guarantee or assurance has been made as to the results that may be obtained.

I understand that in giving my/our consent to treatment, I/we retain the right to refuse any particular exam, procedure, treatment, medication, or immunization that is recommended or deemed medically necessary by the treating health care provider.

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Signature of Parent or Responsible Party Date

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Printed Name of Parent or Responsible Party