EYE CARE Associates

CONSENT FOR TREATMENT OF MINOR

Name of Minor:_____ Date of Birth: _____

Name of parent or legal guardian: _____

Please check [ ] Parent [ ] Legal Guardian

Appointment for: _____

I, (parent or legal guardian) the undersigned, consent permission of care, treatment, and/or dilation, which may include administration of any necessary drops given to my child in relation to today's appointment.

In case of emergency, an effort will be made to reach parent/guardian at the following provided phone numbers: (____) ____-_____ (____) ____-_____

If I am unable to be reached or located within a reasonable time I give my consent to provide the needed medical or surgical services for my child.

Medical Information

Name of Primary Doctor: _____

Contact Number of Primary Doctor: _____

Any known allergies: _____

Medication/s child is currently taking: _____

Other important information the optometrist/ophthalmologist should be aware of:

_____

_____

_____

I have read and fully understand the above information and consent permission of care, treatment, and/or dilation, which may include administration of any necessary drops given to my child in relation to today's appointment.

_____ _____

Signature of Parent or Legal Guardian Date of Consent