Arbor Eyecare

Consent for Treatment of Minor

Name of Minor:_____ Date of Birth:_____

Name of parent of legal guardian:_____

Please Check ☐Parent ☐Legal Guardian

Appointment for:_____

I, (parent of 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 an emergency, an effort will be made to reach parent/guardian at the following phone numbers:

PH (___)_____-_____ PH (___)_____-_____

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

For Payment due at time of service for: copay, contact lens exam, contacts, glasses.

Please contact/ text me at: ☐PH: (___) - _____ ☐TEXT (___) - _____

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