

Medical Consent for Examination and Treatment of a Minor

Child's Name: _____ Date of Birth: _____

Current Medications: _____

Allergies: _____

Pediatrician's Name: _____

Pediatrician's Office Number: _____

Parent/Guardian's Contact Number: _____

Parental/Guardian Authorization of Consent to Treatment of Minor

(I)(We), the undersigned, parent/guardian of _____, a minor, do hereby request and authorize the NECO Center for Eye Care to perform any medical examination, diagnosis or treatment which is deemed advisable during the appointment. This may include the use of diagnostic eye drops to evaluate the patient's ocular health.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, and that it shall remain effective indefinitely, unless sooner terminated in writing.

Check Box and Write Initials if you are authorizing a contact lens exam, along with all associated contact lens fees. I have received and signed the contact lens policy.

_____ (initial here)

Print Name: _____
Name of Parent/Legal Guardian Relationship Relationship

Signature Date

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