visionfirst

PATIENT'S NAME:

DOB:

CONSENT TO TREAT MINOR CHILDREN

I, _____, mother/father, legal guardian of ~patient.first~ ~patient.last~, do hereby consent to any medical and routine vision care determined by VisionFirst to be necessary for the welfare of my child in my absence. I will not be present during the appointment and, therefore, give my consent for my child to be seen by VisionFirst. I also understand that I am responsible for payment of any services rendered during the visit.

ALLERGIES TO DRUGS OR FOOD: _____

_____

SPECIAL MEDICATIONS/OTHER PERTINENT INFORMATION: _____

_____

PLEASE COMPLETE THE FOLLOWING:

1) I give consent for this minor to have an optomap (out-of-pocket charge $35)

   _____ Yes _____ No

2) I give consent for this minor to have a contact lens evaluation (out-of-pocket charge $35-$175)

   _____ Yes _____ No

3) I give consent for this minor to be dilated (no out-of-pocket charge)

   _____ Yes _____ No

_____ _____

Patient or Guardian Signature Date