Consent to Treat Minor Patient: Focus on Kids Optometry

I, _____, parent/legal guardian of _____,

currently a minor (under 18 years of age), whose date of birth is _____ / _____ / _____

I hereby authorize Focus on Kids Optometry to provide and administer eye care as deemed necessary by Dr. Erin Graff.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions I had prior to signing could be answered by calling (308-224-2012).

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Witness Signature Witness Name (Print)

Preferred Phone:

Home (___) Work (___) Cell (___) _____

CONSENT FOR DILATING DROPS

Your child may require dilation drops for his/her eye exam today. Dilating the pupils is usually necessary to provide an accurate diagnosis. The vision is blurred and the eyes are sensitive to bright lights for 3-4 hours but can last up to 2 days in rare cases. Reading vision may be impaired and driving may be difficult.

Allergies to medications: _____

History or Seizures: Yes / No

Signature _____ Date: _____ / _____ / _____

Due to the non-emergency nature of our clinic we do allow a parent to call in and provide verbal consent directly to the provider, but a signed form is preferred.