CONSENT (FOR A MINOR)

I, _____, the parent or legal guardian of
(Parent Name)

_____ born on _____
(Patient Name)

do hereby consent and allow the following individuals to bring the named above patient to their appointment,

_____ _____
(Name of Adult) ***(Relationship to Patient)***

_____ _____
(Name of Adult) ***(Relationship to Patient)***

_____ _____
(Name of Adult) ***(Relationship to Patient)***

to handle any type of ophthalmic medical care for my child including but not limited to the diagnostic testing determined by Ticho Eye Associates Physician.

(Please have the adult bring proper identification to present to the front desk.)

This authorization is effective from on this _____ day of _____, 20____.

_____ _____ _____
Signature of Parent or Legal Guardian ***Date*** ***Print Name***

This consent form should be brought with the child to the physician's Office when the child is taken for treatment. This is additional information will assist in treatment if it can be furnished with the consent but is not required.

Mother's Cell Number_____

Father's Cell Number_____

Allergies to Food or Drugs _____

Special Medications or Pertinent Information:

_____

Child's Physician: _____ Phone: _____