Consent to Provide Medical Care To A Child

(Office use only)
Patient Name:__________________________________________Patient ID Number:___________________________

We request a parent or guardian accompany any child (15 years or younger) to this appointment. \textbf{If you are unable to come to the clinic with your child, please complete this form and have them bring it to their appointment.} Do not mail this authorization.

(Time and date of appointment)

CONSENT VALID FOR THIS APPOINTMENT ONLY

(This section is to be filled out by parent or guardian if minor is 15 years or younger)

I authorize the doctor to take a history, perform an eye examination, and perform diagnostic testing if medically indicated. If treatment is needed the doctor will attempt to reach a parent or guardian as listed below by phone.

I hereby appoint_________________________________ as my representative. I empower him/her to act as legal guardian of medical care and diagnostic testing provided for my child during this appointment.

Signature of parent or guardian:________________________________Date:_______________________________

Daytime telephone number:______________________________Work telephone number, if applicable:________________________

(This section is to be filled out by parent or guardian if minor is 16 to 18 years of age)

I am sending my child without a parent or guardian and I authorize the doctor to take a history, perform an eye examination, and perform diagnostic testing if medically indicated. If treatment is needed the doctor will attempt to reach a parent or guardian as listed below by phone.

Signature of parent or guardian:________________________________Date:_______________________________

Daytime telephone number:______________________________Work telephone number, if applicable:________________________

If you have any questions, please contact Eye Surgeons Associates, P.C.

Silvis - 309-792-2020 Geneseo - 309-944-8888