



### Minor Treatment Consent Form

Please fill out this portion if you are sending your child with an adult who is not his/her parent or guardian:

I, \_\_\_\_\_, as parent / legal guardian of \_\_\_\_\_  
Minor's name Date of Birth

Authorize: \_\_\_\_\_  
Name of designee Address, City, State

Relationship to Minor: \_\_\_\_\_

To consent to any necessary examination, consultation and treatment to be rendered to the above-named minor under the supervision of the Doctors employed by Boling Vision Center. This includes the use of drops to dilate the eyes for examination.

This consent form is considered valid (check one):

from \_\_\_\_\_ to \_\_\_\_\_  
date date

for the duration of my child's care with Doctors employed by Boling Vision Center

Signature of parent / guardian: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Please fill out this portion if your minor child is coming to his/her exam alone:

I, \_\_\_\_\_, as parent / legal guardian of \_\_\_\_\_  
Minor's name Date of Birth

Give permission for any necessary examination, consultation and treatment to be rendered to the above-named minor under the supervision of the Doctors employed by Boling Vision Center in my absence. This includes the use of drops to dilate the eyes for examination.

This consent form is considered valid (check one):

from \_\_\_\_\_ to \_\_\_\_\_  
date date

for the duration of my child's care with Doctors employed by Boling Vision Center

Signature of parent / guardian: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_