# CONSENT TO TREAT MINOR

Patient's Name: _____ Date of Birth: _____

I, _____, the parent or legal guardian of _____ authorize OCEAN EYE to evaluate and treat him/her without my presence. I consent to any medical and/or routine vision care as determined to be necessary for the welfare of my child in my absence. I further agree that any charges incurred regardless of insurance coverage are my responsibility and are subject to insurance plan benefits and limitations.

Allergies to Drugs or Food: _____

Special Medication or other Pertinent Information: _____

_____

---

PLEASE CHOOSE ONE OF THE FOLLOWING –

_____ I give consent for my child to have OPTOS photos taken (32.00 out-of-pocket, not covered by Insurance)
OPTOS is a quick photo of the back of the eye; there are not side effects with this procedure.

OR

_____ I give consent for my child to be dilated (NO out-of-pocket charge, covered by Insurance)
Dilation drops will leave the patient blurry up close and light sensitive, side effects could last for up to 6 hours

*** An Exam will not be performed without one of the above options selected. ***

This document is effective as of _____, and will remain effective until further notice or until the patient reaches eighteen years of age.

Parent Name [printed] _____

Signature _____ Date _____