Bright Family Eye Care
Consent for Treatment of a Minor without a Parent Present

I give my permission for my child/children to be evaluated and treated at Bright Family Eye Care in my absence. I understand that it may be necessary to perform diagnostic tests (for example retinal imaging or OCT imaging) in the course of the evaluation. I accept responsibility for examination and testing charges. If materials (glasses or contact lenses) are ordered in my absence by those given permission to accompany my child I accept responsibility for payment of those fees and copays.

This consent applies to:
1. Comprehensive Eye Examination (including refraction and health testing)
2. Glaucoma testing and Dilation as needed
3. Necessary additional testing
4. First aid and urgent/emergent eye care
5. Problem focused office visits
6. Optical ordering of materials (glasses and contact lenses)
7. Prescription and treatment for eye concerns/issues
8. Referrals to an outside provider for services not provided at the office

If there are any services you do not consent to in your absence, please list:
_____
_____
_____

My child will be accompanied by:

[ ] himself / herself
[ ] babysitter (name) _____
[ ] other (name, relationship) _____

I give permission for the doctor to share any relevant health information with the person who is accompanying my child.

Child / Children's names: Date: _____
_____
_____
_____
_____

Parent or Legal Guardian Sign: _____

Parent or Legal Guardian Print: _____

Phone number where parent or guardian can be reached: _____