VALLEY EYECARE CENTER MEDICAL ASSOCIATES

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CONSENT FOR NON- EMERGENCY TREATMENT OF MINORS

Valley EyeCare Center strongly encourages that a parent or legal guardian accompany any minor children (17 years old or younger) to their medical appointments. In the event that a parent or legal guardian is unable to accompany his or her minor child to a medical appointment, the parent or legal guardian should (1) sign this Consent for Non-Emergency Treatment of Minors and send it to the minor child's health care provider prior to the medical appointment or (2) give it to the minor child to present to the health care provider at the time of the medical appointment. In the event that a minor child presents for a non-urgent medical appointment without a parent or legal guardian or signed consent, **treatment will be denied.**

Name of Child Date of birth _____

Name of Parent or legal guardian _____

If there is a need to reach me during my child's appointment to discuss further care or treatment, I may be reached at the following phone numbers. Home ( ) _____-_____ Cell ( ) _____-_____
Other: _____

Medical Appointment/ Vision exam

I consent to care, treatment, and/or dilation (including administration of any necessary eye drops) at Valley EyeCare Center for my child related to his/her medical appointment on date,
_____ for _____.
Date (month/day/year) (Reason for appointment)

Series of Routine Appointments

I consent to care, treatment, and/or dilation (including administration of any necessary eye drops) at Valley EyeCare Center for my child related to a series of routine appointments from Date,
_____ for _____.
Date (month/day/year) (Reason for appointment)

I understand that in case of a medical emergency involving my child, a reasonable effort will be made to contact me and secure my consent for needed medical services including surgical procedures. If I cannot be located within a reasonable time, however, I consent to any emergency surgery or other medical treatment necessary for my child. I agree to reimburse Valley EyeCare Center for the cost of rendering these services.

_____ _____
Signature of parent or legal guardian Date (month/day/year)

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