



CONSENT TO PROVIDE HEALTH CARE SERVICES TO A MINOR CHILD

This form is provided by Better Vision Family Eye Care to obtain consent from a parent or legal guardian for health care services to be provided to a minor child.

I, _____ (Full Name of Parent/Legal Guardian), hereby consent to Better Vision Family Eye Care providing health care services for my child, _____ (Full Name of Minor), as deemed necessary by our healthcare providers for the health and welfare of said minor child.

This consent includes, but is not limited to:

1. Eye examinations
2. Diagnostic testing (e.g., imaging)
3. Emergency anaphylaxis treatment (e.g., Epipen)
4. Administration of medications (e.g., Topical anesthesia, dilating drops)
5. Prescription of medications
6. Arrange or schedule health care services

This consent is effective from the date of signature and remains effective until revoked in writing.

Minor Child's Information:

Full Name: _____ DOB: _____

Parent/Legal Guardian Information:

Full Name: _____ DOB: _____

Relationship to Minor: _____

Phone Number: _____

Known Drug Allergies: _____

Current Medications: _____

Primary Care Physician/Pediatrician: _____

I understand that by signing this form, I am giving Better Vision Family Eye Care the authority to provide healthcare services for my child as outlined in this document. I assume full responsibility for all costs incurred for medical treatment authorized under this consent.

Parent/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____