NECO | Center for Eye Care
New England College of Optometry

Medical Consent for Examination and Treatment of a Minor

Child's Name: ____ Date of Birth: _____________

Current Medications: ____

Allergies: ____

Pediatrician's Name: ____

Pediatrician's Office Number: ____

Parent/Guardian's Contact Number: ____

Parental/Guardian Authorization of Consent to Treatment of Minor

(I)(We), the undersigned, parent/guardian of ____, a minor, do hereby request and authorize the NECO Center for Eye Care to perform any medical examination, diagnosis or treatment which is deemed advisable during the appointment. This may include the use of diagnostic eye drops to evaluate the patient's ocular health.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, and that it shall remain effective indefinitely, unless sooner terminated in writing.

□ Check Box and Write Initials if you are authorizing a contact lens exam, along with all associated contact lens fees. I have received and signed the contact lens policy.

□ ______ (initial here)

Print Name: ____ ________________________
Name of Parent/Legal Guardian Relationship Relationship

____ ________________________
Signature Date

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