PARENTAL CONSENT FOR TREATMENT & CARE OF A MINOR

I ____ being the parent and or legal guardian of the

minor child ____ date of birth ________________________

hereby give my consent for medically necessary treatment and care, including emergency treatment, to the health care providers at Florida Eye Associates, Inc. If I am not available at a time the minor needs medical care, I give the parties listed below the authority to seek and authorize care. Consent is only valid if signed and dated by the Parent/Legal Guardian and a Witness **over the age of 18.**

Parent/Legal Guardian Signature __________________________Date__________________________

Print Parent/Legal Guardian Name __________________________

Witness Signature __________________________ Date__________________________

Print Witness Name ____________________________________

ALTERNATE PARTIES ATHORIZED TO SEEK MEDICAL CARE FOR MINOR CHILD

Print Name ____ Relationship_________________

Work # ________________ Home/cell # ________________ Initials of Legal Guardian ______

Print Name ____ Relationship_________________

Work # ________________ Home/cell # ________________ Initials of Legal Guardian ______

Print Name ____ Relationship_________________

Work # ________________ Home/cell # ________________ Initials of Legal Guardian ______