

Minor Consent Form



Patient: _____ Date of Birth: _____

If patient is a minor, please complete the following consent form and provide parent or guardian information.

I / We , _____ being the parent(s)/guardian(s) of _____, do hereby request and authorize the optometric physicians of IdealEyes Optometry or persons designated by them to perform necessary services for my child. This is including but not limited to dilation of pupils, whether or not I am present at the actual appointment when the treatment is rendered. It is understood that this consent will be effective for one year from the date of the most recent dated signature, as indicated below.

Signature of Parent/Guardian _____ Date: _____

Signature of Parent/Guardian _____ Date: _____

If parent is not available for signature, verbal authorization may be obtained by phone. The following information must be obtained from the parent/guardian giving permission for treatment.

Patient Full Name: _____ DOB: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

Patient Full Name: _____ DOB: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____