

Consent for Treatment of a Minor Patient

I, _____, parent or legal guardian of

_____, _____ give Norwich Ophthalmology
Child's name *DOB*

Group, P.C. permission to provide any medical and routine vision treatment necessary for the welfare of my child in the event that I do not accompany my child or am not present at the time services are rendered. I also understand that I am responsible for payment of any services rendered during the visit.

Please initial:

_____ I give consent for this minor to have a contact lens evaluation and fitting (\$100 due at time of service).

_____ I give consent for this minor to be dilated.

Parent or Guardian Signature

Date

Parent or Guardian Printed Name