UNIVERSITY EYE SPECIALISTS

Consent to Treatment of a Child by Authorized Persons

The undersigned parent or legal guardian of _____ authorizes the person(s) listed below to
(Child's Name)
consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

2. Medical concerns: _____
3. Known allergies: _____

Name of Parent or Legal Guardian: _____Relationship to Child:_____
(Print Name)

Contact Number(s): _____

Address: _____City, State, Zip: _____

Signature: _____ Date: _____

This consent is effective until withdrawn in writing by the child's parent or guardian.