Proliance
The Children &
Family Eye Doctors

The Children and Family Eye Doctors

a division of Proliance Surgeons

CONSENT TO TREAT MINORS

I, _____, am the parent or guardian of _____ and authorize _____ to be evaluated and treated, if appropriate, by a provider at [Care Center Name]. I further agree to be available by telephone at _____ during the time of my child's appointment if any questions or concerns arise.

Limitations to Authorization, if any: _____
_____

Patient's Name: _____
Patients DOB: _____
Parent/Guardian's Name [Print]:_____
Relationship to Minor: _____

Signature: _____ Date: _____