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TEXAS VISION CLINIC

Consent for Optometric Care, Treatment, and Child's Medical Information

In presenting my son/daughter for diagnosis and treatment

Name:

_____for_____
Mother Father Legal Guardian Son Daughter

of _____ years of age, hereby voluntarily consent to the rendering of Optometric routine care, diagnostic procedures, and medical advice, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents. We/I hereby give our (my) consent to

_____
(Name of Person/Agency) who will be caring for our (my) child

_____
(Name of Child)

for the appointment on_____
(Date)
to arrange for routine care and treatment necessary to preserve the health of our (my) child's eyes and vision. We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____
Address:_____
Telephone no.: _____
Name of health insurance carrier: _____
Group no.: _____
Member ID no: _____
Doctor or Surgeon (If referral or surgical patient):_____
Child's allergies, if any: _____
Medicines child is taking: _____

Signature: _____
Date: _____
Mother, Father or Legal Guardian Witness: _____
Date: _____
In case of emergency I can be reached at:
_____