



EYE ASSOCIATES
NORTHWEST

Parental consent for dilation and or treatment of a minor

I, _____, the parent or legal guardian of
Parent or guardian, please print

_____, authorize the dilation of his/her eyes for a routine
Child's name, please print

eye exam and or necessary medical treatment deemed necessary by qualified
medical personnel. This form will remain in effect until revoked in writing by me.

Parent or guardian signature

Date