

MINOR CHILD MEDICAL/SURGICAL TREATMENT AUTHORIZATION

I hereby present my son/daughter for diagnosis and treatment:

NAME: _____

MOTHER FATHER LEGAL GUARDIAN

for _____

SON DAUGHTER

minor child date of birth _____ . I hereby voluntarily consent to the rendering of such care, including diagnostic procedures(such as eye drops, etc), surgical and medical treatment, by authorized members of **Peninsula Eye Physicians Medical Group** or their designees, 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 examination 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 **Peninsula Eye Physicians Medical Group** who will be caring for our (my) child, whose name is listed above, for the period _____ to _____ to arrange for routine or emergency medical care and treatment.

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: _____

PHONE: _____

SIGNATURE: _____ DATE: _____
(Mother, Father, or Legal Guardian)

In case of emergency I can be reached at: _____

WITNESS: _____ DATE: _____