

# CONSENT TO TREAT MINOR PATIENT

## Indiana University School of Optometry

This form provides authorization by a parent or legal guardian for another adult to consent to treatment of a minor during the absence of the parent(s) or legal guardian. This form may be on file with the Indiana University School of Optometry prior to a scheduled appointment or presented at the time of an appointment.

Minor's Name (Last, First, Middle)	
Date of Birth (MM/DD/YY)	
Allergies	
Current Medications	
Chronic Conditions or Health Concerns	

List individuals who are authorized to accompany and consent for treatment of the minor, for example a grandparent, caregiver, or adult sibling:

Name	Relationship to Patient

- I pre-authorize the Indiana University School of Optometry and its personnel to deliver routine vision care and services to the minor when accompanied and consented by an individual listed on this form. Further consent from the parent or legal guardian may be necessary if a procedure requires informed consent.
- I understand that insurance information must be presented at the time of the appointment and the adult accompanying the minor is responsible for payment of the patient portion at the time of service.
- I understand I may revoke this authorization at any time and must do so in writing to the Indiana University School of Optometry.

Printed Name of Parent or Legal Guardian	
Telephone Number	
Signature of Parent or Legal Guardian	
Date	
Staff Signature for Receipt of Verbal Authorization	
Date	