INDIANA UNIVERSITY SCHOOL OF OPTOMETRY
CONSENT TO TREAT MINOR PATIENT

This form provides authorization by a parent or legal guardian for another adult to consent 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/yyyy

Allergies: _____

Current Medications: _____

Chronic Conditions or Health Concerns: _____

_____

List the 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

_____ _____
Name Relationship to Patient

_____ _____
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 an informed consent.
- I understand that the 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.

_____ _____
Name of Parent or Legal Guardian (please print) Telephone Number

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Staff Signature for Receipt of Verbal Authorization Date