

# Consent for Evaluation/Examination of Minor Child

Minor Child Name:	
Chart #:	Date:
Name of Parent or Legal Guardian:	

I am the parent and/or legal guardian for my minor child. I give my written consent for my minor child to be examined and treated at Carolina Ophthalmology Associates.

Carolina Ophthalmology Associates prefer that the parent/legal guardian accompany their child at the time of any evaluation or examination. However, if you cannot accompany your child, please complete the following:

Name of person who may accompany the above named minor child in absence of the parent or legal guardian: \_\_\_\_\_

**I certify that I have the legal authority to execute this document as parent, legal guardian, or under other circumstances.**

Parent, relative or legal guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Witness' signature: \_\_\_\_\_