CITY OF VISION
EYE CARE

Consent to Medical Treatment of Unattended Minors

To Parents and Guardians:

This form allows parents or guardians to give consent for medical treatment of unattended minors in case of emergencies.

At City of Vision Eye Care, we prioritize the health and well-being of every patient. We value your trust in us to care for your minor child and aim to provide the best possible healthcare.

General Consent Requirement:

We require parental or guardian consent to treat minors (under 18). Given that parents often have other commitments, we understand you may not always be able to accompany your child to appointments. If a minor arrives alone or with an adult who isn't a parent or guardian, they must have written consent for treatment. Without this, the appointment will be rescheduled.

Consent Form:

To ensure your child's appointments are not delayed, we offer a consent form. Once completed by a parent or guardian, this form will be kept in your child's medical record. It authorizes us to provide necessary routine and medical treatment, including digital imaging such as the Optomap, as required. This consent remains effective until revoked in writing.

Exceptions:

By law, minors can consent to certain healthcare services without parental consent if they are emancipated, married to someone 18 or older, or in emergencies.

We are committed to providing healthcare in your child's best interests. For questions, please contact us before your child's appointment.

☐ I, the parent or legal guardian of the unattended minor, do hereby authorize the physicians at City of Vision Eye Care to perform the medical treatment as per the statements. I have read and acknowledge that decisions can be made by my unattended minor or designated proxy, as I have designated on the following page.

Minor Patient Information

Patient's Name (1)

Date of Birth (1)

Patient's Name (2)

Date of Birth (2)

Patient's Name (3)

Date of Birth (3)

Parent, Proxy & Emergency Contact Information

Parent/Guardian Name

Parent/Guardian Phone

Authorized Proxy Name(s)

Relationship to Patient

Proxy Phone Number

Emergency Contact

Emergency Contact Phone

☐ I authorize the individual(s) listed above to discuss my child's care, appointments, billing, and medical information with City of Vision Eye Care and to serve as emergency contacts when needed.

E-Signature (draw, upload or type)

Date: