Poole
Eye Associates

Consent for Medical Treatment of a Minor

Patient Name _____ Patient Date of Birth _____

All minors seeking medical treatment must be accompanied by a parent/legal guardian during the first office visit for medical problem. After the initial appointment, a minor may be seen for treatment only with written authorization from the parent/guardian under the conditions specified in this consent. If the parent/legal guardian cannot attend the appointment, the following instructions that you select will be adhered to in the treatment of the minor patient:

Comprehensive Exam & Testing:
yes/no ***I authorize Poole Eye Associates,P.A. to diagnose, test, and treat the minor as deemed necessary by the provider***.

Materials:
yes/no ***I authorize Poole Eye Associates, P.A. to fill a spectacle or contact lens rx under the diagnosis and treatment of the provider.***

Financial:
yes/no I authorize my minor to make all financial decisions on his/her account.

NEW PRESCRIPTIONS:
yes/no ***I authorize Poole Eye Associates, P.A. to write new prescriptions for the minor as deemed necessary for treatment for medical purposes.***

OFFICE PROCEDURES:
yes/no ***In the absence of a parent/guardian/appointed adult, I authorize the minor patient to sign any required consent forms for treatment of dry eye, foreign body removal, eye infection, dilation etc.***

If you need to send your child to their appointment with an adult other than yourself/legal guardian, please complete this section:

I appoint the following adult _____, whose relationship to the child is _____, to consent to medical care which is deemed necessary by Poole Eye Associates, P.A. as authorized herein. A parent/ legal guardian may appoint another adult to accompany the minor patient to the appointment. If the parent/legal guardian is not available, the Texas Family Code allows only certain adults to consent for medical treatment to minors if parental consent cannot be obtained. These are: a grandparent, an adult brother, sister, aunt or uncle, and any adult who has actual care, control, and possession of the minor and has written authorization to consent from the parent/legal guardian.

I, _____, am the parent/legal guardian of the minor child _____. I have the legal right to consent for medical treatment for this patient. I hereby authorize Poole Eye Associates,P.A. to provide medical treatment as indicated above. I understand that this consent will be valid for 12 months from the date signed unless revoked by me in writing.

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date