# CONSENT TO PROVIDE HEALTH CARE SERVICES TO MINOR CHILD

I, _____ (parent or legal guardian), give written consent to Central Florida Eye Center, PA to arrange, schedule, and/or provide health care services, including the administration of topical anesthesia and prescription of medicinal drugs to _____ (minor child), as deemed necessary for the health and welfare of said minor child. The authorization is effective from the date of signature.

_____ I give consent for my child to have their eyes dilated.

_____ I DO NOT give consent for my child to have their eyes dilated.

_____ _____

Minor Child's Name DOB:

_____ _____

Signature of Parent or Legal Guardian Date

_____

Relationship to Child

Known Drug Allergies: _____

Current Medications: _____

Primary Care Physician: _____