Consent for Treatment of Minor

This will authorize Dr. Traci L. Schmalle, Dr. Jana K. Murakami and other doctors working at this office to provide vision and medical eye care including examination, refraction, diagnostic procedures, and treatment to the following minors under your guardianship:

Name	DOB	Name	DOB

_____
Initials

□ This form authorizes said minor to present for minor care and treatment **unaccompanied by an adult**.

_____
Initials

□ This form authorizes said minor to present for minor care and treatment **accompanied by an adult other than his/her parent or legal guardian**.

It is understood that this authorization is given in advance of any specific diagnosis or treatment in order to avoid delay in providing such treatment as is deemed necessary by Dr. Traci L. Schmalle or other doctors under her supervision.

This authorization to treat will remain in effect until the patient is 18 years of age unless revoked sooner in writing.

Date	Signature of Parent/Legal Guardian/Person having legal custody	Print name of Parent/Legal Guardian	Relationship

**Copies of this form are available upon request.*