Northside Vision
"Better Vision for a Better Life."

CONSENT TO MEDICAL TREATMENT OF UNATTENDED MINORS

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

I, the undersigned, parent(s) or legal guardian of the above named patient(s), a minor, do hereby authorize the optometrist at Northside Vision, LLC to act as agent(s) for the undersigned to consent to ocular examination, **dilation**, medical diagnosis and treatment or other medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, the treating physician who is licensed to practice in the state of South Carolina, whether such diagnosis or treatment is rendered at the office of said physician. **I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance.**

Consent to Treat a Minor Child accompanied by an adult other that the child's parent or legal guardian

I, the parent or legal guardian of the patient(s) named above, do hereby authorize the physicians at Northside Vision, LLC to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's name:_____Relationship to the child:_____

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Adult's name:_____Relationship to the child:_____

This authorization is valid for: For any and all medical procedures including instillation of eye drops for eye pressure & **dilation** (typically covered by insurance).

Parent of legal guardian: (Print Name)_____Date:_____

Parent or legal guardian signature:_____