PATIENT NAME: ____ **DATE:**_____ /____ /___________

CONSENT TO TREAT MINOR

Name of Parent or Legal Guardian	Date of Birth	Last 4 of SSN	Phone #

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Are parents married? **YES** **NO** **N/A** If no, who has primary custody? ______________________________________*

Please provide proof of custodial guardianship if not the biological parent.

DILATED/CYCLOPLEGIC EXAM

(Only ordered if necessary)

Dilating drops enlarge the pupils (lasts 4-6 hours). Stronger (Cycloplegic drops) are used to relax the focusing power of the eyes for a more accurate measurement for glasses (lasts 24 hours).

If recommended by the doctor, do you consent to have your child's eyes dilated? YES NO

Answer the following questions about your child's history:

Complications with birth	**YES**	**NO**
Delayed learning to crawl/walk	**YES**	**NO**
Developmental Delays	**YES**	**NO**
Learning Disabilities	**YES**	**NO**
ADHD or ADD	**YES**	**NO**
Autism Spectrum	**YES**	**NO**
Severe allergies	**YES**	**NO**
History of eye infection/injury	**YES**	**NO**
History of styes	**YES**	**NO**
Had to repeat a year in school	**YES**	**NO**
Poor grades/struggling in school	**YES**	**NO**
Reading at or above grade level	**YES**	**NO**

How often does your child experience:	**NEVER**	**SOME TIMES**	**OFTEN or ALWAYS**
ANSWER FOR CHILDREN **AGES 1-4**:			
Avoids looking at picture books/puzzles			
Poor eye contact/does not track with eyes			
Spends > 2 hrs/day on electronic devices			
ANSWER FOR CHILDREN **AGES 5-16**:			
Difficulty seeing words on the board			
Writes uphill/downhill or misaligns digits			
Spends > 4 hrs/day on electronics			
WHEN YOUR CHILD IS **READING** (if applicable):			
Blurry vision, words run together			
Misreads or skips words or lines, loses place			
Falls asleep reading/loses attention quickly			
WHEN YOUR CHILD PLAYS **GAMES OR SPORTS**:			
Avoids playing/poor sports performance			
Poor hand-eye coordination			
Poor judge of distance/depth perception			
ANSWER FOR **ALL AGE** CHILDREN (if applicable):			
Excessive clumsiness/runs into walls			
Double vision, closes one eye, head tilt			
One eye turns in or out (like a crossed eye)			
Sits or stands too close to TV, squints to see			
Holds things too close to their face to see			
Burning, itchy, water eyes, rubs eyes			
Red "blood-shot" eyes or puffy eyelids			
Mucus discharge or crusting on eyelashes			
Blinks excessively or hard blinks			
Complains of headaches or eye pain			
Sensitive to light			

I consent to have my child examined by the doctors and staff of Sylvester Eye Care. I have reviewed the options to consent to dilation or cycloplegia if needed. By signing below, I attest that I am the legal guardian with the authority to sign for my child.

Printed name of Parent or Legal Guardian	Signature of Parent/Legal Guardian	Date Signed

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sylvester EYE CARE & AESTHETICS