Ketchum Health
5460 E. La Palma Ave,
Anaheim, CA 92807

CONSENT FORM FOR TREATMENT OF MINORS

The undersigned parent/legal guardian of _____ does hereby
Name of minor and age

empower and grant to _____
Name phone number

the right to consent permission of any examination, medical diagnosis, tests, treatment, including dilation, to be rendered for my child/ward. This authorization shall be valid for the visit commencing on _____and ending_____. I do hereby indemnify and hold harmless the Eye Care Center and any optometrist or intern who act in reliance upon this authorization.

Executed this_____day of _____

_____ _____
Parent Witness

_____ _____
Legal Guardian Witness

Important Medical Information

Parent/Guardian can be located at the following address/phone: _____

_____

Name(s)/ Phone number of family doctor: _____

Any known allergies: _____

Any medication child currently takes: _____

Medical problems/conditions requiring special attention: _____

_____

List other important facts about your child our optometrist must be aware of: _____

_____