PEDIATRIC OPHTHALMOLOGY of Erie

AUTHORIZATION FOR EXAMINATION (MINORS)

Unless a court has stated otherwise (and a formal legal document can be provided to us), the parents listed on the birth certificate are the only people allowed to approve medical care being provided to a child. If a parent or LEGAL guardian is not bringing the child to his/her appointment, then we need permission from the parent that we can see that child. Please complete the following information to authorize us to see your child with the following people you would like to be able to bring your child to appointments.

I, the parent/guardian, give the physicians and clinical staff permission to examine, instill drops and administer necessary tests to the following patient(s) without my presence. I swear that that the information below is correct, and that I am the parent/legal guardian of the below mentioned patients**.**

I AUTHORIZE the following people to bring my child(ren) to see the doctors of Pediatric Ophthalmology of Erie, Inc.:

NAME: _____RELATIONSHIP (TO CHILD): _____DOB: _____

NAME: _____RELATIONSHIP (TO CHILD): _____ DOB: _____

My following child(ren) are allowed to be escorted to his/her appointments by the above-mentioned people:

PATIENT'S NAME: _____ DOB: _____
PATIENT'S NAME: _____ DOB: _____
PATIENT'S NAME: _____ DOB: _____

PARENT/GUARDIAN NAME: _____

SIGNATURE: _____

DAY-TIME PHONE NUMBER: _____ALTERNATE PHONE NUMBER: _____

CONTACT INFORMATION OF ANOTHER PARENT/LEGAL GUARIAN IF I'M UNABLE TO BE REACHED DURING THE PATIENT'S EXAM:
NAME: _____RELATIONSHIP: _____

PHONE NUMBER: _____ALTERNATE PHONE NUMBER: _____

FOR STAFF USE - AUTHORIZATION FOR EXAMINATION

NAME OF PARENT/GUARDIAN CONTACTED: _____

□ Parent/guardian confirmed permission for all aspects of exam. Employee's initials: _____ Date/Time: _____
□ Other: _____

Account #_____