

# LA GRANGE EYE CARE

657 E. Travis, Suite B La Grange, Tx 78945

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## CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

La Grange Eye Care must receive permission from a child's parent or legal guardian before providing treatment in non-urgent situations. This form gives us legal permission to treat your child in the event that you cannot accompany them to the clinic for treatment. If the party accompanying your child (baby-sitter, friend, relative, ect.) does not present this information, treatment may be denied.

**Please send the insurance card and copay (if applicable) to the appointment.**

Name of Health/Vision  
Insurance: \_\_\_\_\_

Policy Holder's Name & DOB:  
\_\_\_\_\_

Identification Number:  
\_\_\_\_\_

Group Number: \_\_\_\_\_

### Child's Health Information

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Other Important Medical  
Info: \_\_\_\_\_

I grant \_\_\_\_\_ (accompanying adult) to arrange for and authorize routine & emergency treatment at La Grange Eye care on (date) \_\_\_\_\_. This adult will be responsible for communicating all treatment discussions/ decisions to the parent/guardian. La Grange Eye Care and its providers will not hold a separate phone discussion with the parent/guardian after the visit.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I wish to give consent for the minor to receive medical care without an accompanying adult. This consent only applies to minor's age 17+.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_