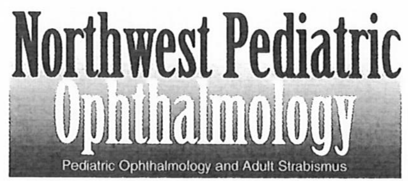

Christina N. Nye, M.D.
Caroline J. Shea, M.D.
Rick Whitehead, M.D.

Eye Physicians and Surgeons

Advance Consent to Treat Minors

This form is to be used in the event that a parent/legal guardian is not always available to bring their child to their medical appointments. **Please be aware that without this signed authorization on file, you would otherwise need to provide a written note in order for anyone other than parent/legal guardian to accompany your child to their appointments.** Please note anyone included in this authorization must be over the age of 18.

I,____, the parent or legal guardian of my child,____, authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel of **Northwest Pediatric Ophthalmology.** This authorization will remain in effect until revoked in writing by me.

____ ____________________________

Signature of parent/legal guardian Date

________________________________ ________________________________

(Name) (Relationship to patient)

________________________________ ________________________________

(Name) (Relationship to patient)

________________________________ ________________________________

(Name) (Relationship to patient)

________________________________ ________________________________

(Name) (Relationship to patient)

________________________________ ________________________________

(Name) (Relationship to patient)

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