MEDICAL CONSENT FORM

Authorization by parents for another to consent to medical treatment, hospitalization, surgery or special medical procedures during absence of parents.

Date: _____

Parent's Names: Mother:_____

Father: _____

Name(s) of Child (Children):_____ DOB____/____/____

_____ DOB____/____/____

I/We Hereby Appoint: Name: _____Phone_____

*Relationship to child*_____

Address:_____

City:_____State_____Zip_____

as the person who, during my/our absence from _____, shall be authorized to consent for all medical and/or special procedures which may be required during my/our absence.

List ***allergies*** and ***current medication*** if any:_____

(Child's allergies/medication)

Kentucky Eye Care, P.S.C., its officers and personnel and any physician providing medical or surgical services to any child named above may rely upon the consent of authorization executed by the above named appointee with the same force and effect as if personally executed by me/us.

In consideration of the services, which are rendered to any, named above, pursuant hereto, we agree to pay for all such services. This authorization shall be effective until **a)**_____, 200____

(Strike out inapplicable term) *Month* *Date*

b) until revoked in writing.

_____ _____

(Parent signature – Mother) (Parent signature- Father)

In the event that only one parent executes this form, please state below the reason why the signature of the other parent cannot be obtained_____.

If the child is under guardianship, then the guardian should execute this authorization.