MECA
Munster Eye Care Associates, P.C.
Comprehensive Ophthalmology/Optometry and Optical Dispensary
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Consent of Minor Examination Form

I. Minor child 15 years of age or younger: Authorization by parent/legal guardian for a designated individual to accompany a minor child during routine examination by Munster Eye Care Associates, P.C. during the absence of parent/legal guardian. (i.e. grandparents, step-parent without guardianship or any person designated by the parent/legal guardian over the age of 18.) Please complete authorization I.

II. Minor child between the ages of 16 and 17: Authorization by parent/legal guardian to perform routine examination of minor child by Munster Eye Care Associates, P.C. during the absence of parent/legal guardian. Please complete authorization II.

This form only applies to examination or examination with contact lens fitting. Parent/legal guardian must accompany minor child for all other treatment.

Minor Information

I authorize for the following service(s): ☐ Routine Examination Only ☐ Routine Examination with Contact Lens Fitting

Reason for examination: _____

First Name	Last Name	Birth date
~patient.first~	~patient.last~	~patient.birth~

Allergies: _____

Current Medications: _____

Medical Alert/History: _____

Parent or Guardian Contact Information

Last Name_____ First_____ MI_____

Street Address_____ City/State_____ Zip____

Home Phone # ( ) _____ Work Phone # ( ) _____ Cellular # ( ) _____

Spouse's Name and Address if different from above _____

Home Phone # ( )_____ Work Phone # ( ) _____ Cellular # ( ) _____

In an Emergency, if Parents/Guardians Cannot be Contacted

Contact Name _____ Contact Phone # ( ) _____

Relation to Minor _____

Primary Care Physician _____ Doctor's Phone # ( ) _____

☐ Authorization I: I/We hereby appoint _____
name phone relationship
as the person who, during my/our absence shall be authorized to accompany my/our minor child or children during a routine examination and/or contact lens fitting at the office of Munster Eye Care Associates, P.C. on _____, 20___ and if necessary, authorize _____ to consent to initiate any medical or first aid treatment for my above-named minor child or
name
children in the event of significant injury or illness. I understand that an attempt will be made to contact me in the most expeditious manner possible. If in that event I cannot be reached, the treatment necessary for the best interest of the above-named minor child or children may be initiated. I have read the above statement and I hereby give my written consent.

☐ Authorization II: I hereby grant consent to Munster Eye Care Associates, P.C. to see my minor child during a routine examination and/or contact lens fitting in the office on _____, 20___ and if necessary, to initiate any medical or first aid treatment for my above-named minor child or children in the event of significant injury or illness. I understand that an attempt will be made to contact me in the most expeditious manner possible. If in that event I cannot be reached, the treatment necessary for the best interest of the above-named minor child or children may be initiated. I have read the above statement and I hereby give my written consent.

Signature of Parent or Legal Guardian _____ Date _____

Witness _____ Date _____

If the child or children are under legal guardianship, then the legal guardian must show proof of designation.