COMPLETE FAMILY EYECARE & OPTIQUE, P.C.

2320 ATLANTA HWY, STE 103 CUMMING, GA 30040
TEL. 678.965.5558 FAX. 678.965.5502

chrisbo@cfega.com

Parental Consent Form For Ophthalmic Treatment

Child's Name ______________________________ **Date** ______________________

Child's Date of Birth __________________________

Your child is in need of some basic eye care. This form explains the care that your child needs, and requests your permission to provide that care.

❑ **Eye Health Exam**- includes refraction to determine prescription

❑ **Dilation of the Eyes**- Dilating drops allow the doctor a view into the eye to examine the retina (back of the eye) and evaluate the health of the eye

❑ **Fundus Photo**- 200° digital image of the retina (back of eye) **WITHOUT** the use of dilating drops

❑ **Contact Lens Management**- evaluation of the eye health and fitting of contact lens regulated as a medical device

❑ **Medical Treatment**- evaluation of urgent eye conditions that for example: pink eye, eye irritation, removal of foreign body, flashes of light, etc…

❑ **Other**: ____

____

We expect the child will need approximately __________ appointment(s) to complete this(these) service(s).

❑ I understand that my child ____ needs to receive the ophthalmic services explained and checked above from Complete Family Eyecare.

❑ I give my consent for all these services

My consent for these services expires ______________________________
(Date)