NEWTON WELLESLEY EYE ASSOCIATES, P.C.
2000 Washington Street, Suite 462, Newton, Mass.
65 Walnut Street, Suite 301, Wellesley Hills, Mass.
Telephone (617) 964-1050 Fax (617) 964-6449

Medical Consent

Parental/Guardian Medical Consent Form

Patient Information

Child's name: _____

Child's D.O.B. _____ Age: _____

Allergies: _____

_____

Current medications: _____

_____

Pediatrician's name: _____

Pediatrician's office number: _____

Parental/Guardian Authorization of Consent to Treatment of Minor:

(I)(We), the undersigned, parent/guardian of _____,

a minor, do hereby request and authorize Dr. _____ to perform any medical examination, diagnosis or treatment which is deemed advisable during the appointment occurring on _____ at Newton Wellesley Eye Associates, P.C.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, and that it shall remain effective for ninety (90) days from date of signature below, unless sooner terminated in writing.

Please print: _____ _____
Name of parent or legal guardian Relationship

_____ _____
Signature of parent/legal guardian Date