# Authorization for Evaluation and/or Treatment of a Minor Child
# Unaccompanied by Parent or Legal Guardian

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all visual and/or medical treatment provided by Michael M. Monson, O.D. or Cody P. Blom O.D. Please complete this form if your child will be coming for a visit, treatment or procedure without a parent or legal guardian. This consent is valid for the specified time period with a maximum of one year from date signed. Please choose the appropriate option (1 or 2) below.

**MINOR PATIENT:**

**Name:** ______________________________________________________________________________

**Address:** ____________________________________________________________________________

**City:** ________________________ **State:** _____________________ **Zip:** __________________________

**Date of Birth:** _______________________________ **Phone:** ____________________________________

**Time Period:** Written consent is valid for the time period of: ___________ to _____________. (Not to exceed one year) at which time a new consent form would be required. This consent may be revoked by me at any time in writing.

1. **AUTHORIZATION FOR OTHER INDIVIDUAL TO ACCOMPANY MINOR PATIENT UNDER 18 YEARS OF AGE:**

I authorize ___________________________________ ___________________________________

(Name of person(s) being authorized Relationship to Patient

To give consent for visual/medical treatment by Michael M. Monson, O.D. or Cody P. Blom O.D. on behalf of my child listed above. The above-named individual(s) may also receive test results and additional information pertinent to the care and treatment of this minor child. I understand that I am still financially responsible for all expenses incurred by my child during these appointments.

______________________________________________________________________________

Parent/Legal Guardian Date Signed

_______________________________________________________

Phone number (in case of emergency)

2. **AUTHORIZATION FOR MINOR PATIENT TO BE UNACCOMPANIED FOR TREATMENT BY MICHAEL M. MONSON, O.D. or CODY P. BLOM, O.D.**

I authorize and give consent for my child, listed above to go independently to appointments and consent for all visual and/or medical treatment without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments.

______________________________________________________________________________

Parent/Legal Guardian Date Signed

_______________________________________________________

Phone number (in case of emergency)

PLEASE HAVE AUTHORIZED INDIVIDUAL PRESENT THIS FORM WITH EACH VISIT.