WRIGHT
EYE CARE CENTER

❑ **J. Britt Wright, OD**
Therapuetic Optometrist
Optometric Glaucoma Specialist

❑ **Stephen G. Slade, MD**
Surgical Director

CONSENT TO TREAT MINOR

I/We, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physicians of Wright Eye Care Center to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but not limited to: Wellness Eye Exam, Contact Lens Exam and digital photography for retinal exam.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgement as to the requirements of such diagnosis or medical treatment in my/our absence.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s), or until minor may legally consent for him or herself.

____ ____________________

Minor's Name in full **Date of Birth**

____ ____________________

Parent or Legal Guardian Signature Date

____ ____________________

Witness Date

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wrighteye2020.com