

McCormick & Bouchard Eye Care

5 Edwards Avenue

Damariscotta, ME 04543

Consent to Treat Minor without Parent/Guardian

Patient Name: _____

Parent/Guardian Name: _____

I, _____, the parent or legal guardian of my child, _____, authorize and consent **McCormick & Bouchard Eyecare** to provide routine and emergency treatment for my child when deemed necessary by optometrist. This authorization is given in advance to any specific treatment being required and I wave my right of prior informed consent to each treatment. This authorization is in effect until revoked in writing by me.

Signature of Parent/Guardian: _____ Date: _____

Phone Number: _____