Parental Authorization for Examination And Treatment

Date: _____

I _____, hereby authorize _____ to
(Print Name Custodial Parent /Legal Guardian)

accompany my child to Dr. Yancey's Office for a comprehensive eye examination including dilation, and authorize any medical treatment needed.

Authorized individual must accompany child at all times.

This authorization will remain in effect unless otherwise cancelled by custodial parent or legal guardian in writing for no less than 90 days from date of signature.

_____ _____

(Print Name) (Sign Name) (Date)