PERMISSION TO EXAMINE MINOR CHILDREN

DATE: ________________________

I hereby give permission for Dr. _________________________ to examine, using any

medications or eye drops, including dilating drops, if necessary, to diagnose and

treat __________________________________. I hereby certify that I am the

____________________________________ of the above named child.
(relationship)

____
(signature)

Parent SS#: __________________________

Parent Work #: ______________________

Form: 0301