Coastal Family 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 Coastal Family Eye Care 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: _____