UNIVERSITY EYE ASSOCIATES
Doctors of Optometry, P.A.
Excellence In EyeCare

Consent toTreat a Minor
Unaccompanied by Parent or Legal Guardian

Dr. Kenneth W. Best
Dr. Magda M. Metwalli
Dr. Robert C. Hamp
Dr. Claire H. Schmidt
Dr. Michelle Q. Do
Dr. Emilie K. Seitz
Dr. Marie E. Huegel
Dr. Carlene M. Solomon

Patient Name: _____Date of Birth: ____/____/____

This consent allows a minor to be seen at University Eye Associates when a Parent or Legal guardian cannot accompany them. The Parent or Legal guardian must complete and sign this consent form. Without this signed consent, treatment may not be provided to the minor.

The provider has the right to cancel or reschedule the appointment until the Parent or Legal guardian accompanies the minor, if it is in the best interest of the minor patient.

In most cases, informed consent must be given from the minor's parent or legal guardian.

- Under **North Carolina** law, a person under the age of 18 is a minor. There are limited circumstances in which a minor can consent to his or her treatment.

For new patients:

All patients under 18 years of age **must** have a Parent or Legal guardian with them for their first visit. If not, they will be asked to reschedule the appointment.

Parent/Legal Guardian's Information
(please print)

Last Name		**First Name**	
Date of Birth		**Relationship To Patient**	
Driver's License #		**Phone Number**	

Please initial below. This is a required permission.

_____ I give University Eye Associates permission to treat my child.

This consent will expire on the following event: ☐ Minor's 18th birthday ☐ End of the calendar year

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This treatment may include, but is not limited to:

- Eye examination
- Dilation
- Patient Education

FOR OFFICE USE:

Patient ID: _____