Marciano Family Vision Associates

A MEMBER OF VISION SOURCE™

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CONSENT TO PROVIDE HEALTH CARE SERVICES TO A MINOR CHILD

I, _____, parent or legal guardian of **_____,** give written consent to **Marciano Family Vision Associates and its doctors, Mark T. Marciano, Brandee Marciano, and Steve Silverstone** to arrange, schedule and/or provide health care services including, but not limited to topical anesthesia, dilation drops, and prescription of medicinal drugs as deemed necessary for the health or welfare of minor child. The authorization is effective from the date of signature.

_____ _____

Minor Child's Name **Date of Birth**

_____ _____

Signature of Parent or Legal Guardian **Date**

_____

Relationship to Child

Drug Allergies: _____

Current Medications: _____

Primary Care Physician: _____