

- Cataract Surgery • Laser Vision Correction • Comprehensive Ophthalmology • Neuro-ophthalmology • Uveitis • Cornea & External Disease • Glaucoma
- Ophthalmic Plastic and Reconstructive Surgery • Cosmetic Eyelid Surgery • Pediatric Ophthalmology • Pediatric & Adult Strabismus Surgery
- Medical and Surgical Disease of the Retina • Audiology

### PERMISSION TO ACCOMPANY A MINOR

I, \_\_\_\_\_ the parent or legal guardian of \_\_\_\_\_  
 \_\_\_\_\_ (name of child) residing at \_\_\_\_\_  
 \_\_\_\_\_ (address) born on the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
 do hereby consent and allow \_\_\_\_\_ (name of adult to be  
 accompanying child) to accompany my child and authorize treatment for my child in  
 accordance with the office policy of Pediatrics. This includes but is not limited to  
 accompanying the child into the exam room, signing all necessary documentation upon  
 check-in, providing proof of valid health insurance, proving the child's medical history  
 and a history of present illness, authorizing any/all treatment during the exam including  
 the instillation of dilating eye drops if necessary. This adult has the responsibility to relay  
 any diagnosis, treatment plan or prescription(s) to the parent or legal guardian  
 mentioned above. This adult must provide a valid photo ID at the time of check-in. I as  
 the parent/legal guardian agree to be available by phone and to be financially responsible  
 for all copays and coinsurance.

This authorization is effective from: \_\_\_\_\_ (effective date) and will  
 remain in effect until I authorize cancellation by having this consent removed from the  
 chart.

#### Child's Health Information

Current prescribe or over-the counter medications and dosages:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Allergies, history of illnesses or other comments: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

#### Emergency Contact Information for Parents/Guardians:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Best # to Contact: \_\_\_\_\_ Alternative #: \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

<b>SUFFOLK</b>	<b>BRENTWOOD</b>	<b>HOLBROOK</b>	<b>RIVERHEAD</b>	<b>SOUTHAMPTON</b>	<b>NASSAU</b>	<b>NEW YORK CITY</b>
AMITYVILLE 805 Broadway, Ste 106	601 Suffolk Avenue	233 Union Avenue, Ste 105	54 Commerce Drive, Ste 6	186 Old Town Road	BETHPAGE 4277 Hempstead Turnpike	MANHATTAN 114 East 27th Street
BABYLON 500 West Main Street Suite 210	DEER PARK 590 Nicolls Road	HUNTINGTON 700 New York Avenue, Lower Level	SAYVILLE 153 Main Street	SOUTHOLD 41705 County Road 48	GARDEN CITY 520 Franklin Avenue, Ste 251	QUEENS 5515 Little Neck Parkway Ste L10
BAY SHORE 375 E. Main Street, Ste 24 180 E. Main Street	HAMPTON BAYS 223 W. Montauk Highway, Ste 101	PATCHOGUE 250 Patchogue-Yaphank Road, Ste 1	SMITHTOWN 260 Middle Country Road, Ste 201 260 Middle Country Road, Ste 109	WEST ISLIP 786 Montauk Highway	HEMPSTEAD 230 Hilton Avenue, Ste 207	
	HAUPPAUGE 110 Marcus Boulevard, Ste 400	PORT JEFFERSON STATION 1500 Route 112, Building 6		ROCKVILLE CENTRE 119 N. Park Avenue, Ste 208		