SightMD® Connecticut
(860) 649-9973

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