Arlington Vision Center
524 N McLeod Ave
Arlington, WA 98223
Phone (360)435-2043
Fax (360)435-6014

CONSENT TO TREAT A MINOR FORM

Being the parent or legal guardian of _____(minor's printed name).
I _____ (parent/guardian's printed name) do consent to the examination of the eyes and rendering of such care, including diagnostic procedures and medical treatment that may be deemed necessary for my minor child. Further, I understand I am financially responsible for any cost incurred for my child's care. This includes copays, coinsurance and cost not covered by insurance. I understand that the doctor and other providers attending to my child will take all reasonable safety precautions during their care.

Parent/Guardian Signature: _____ Date:_____

CONTACT LENS or GLASSES

I am giving permission for _____(minor's printed name).
To receive the additional exam, training and expense that may be required for contacts or glasses. .

Parent/Guardian Signature: _____ Date:_____

- □ GLASSES
- □ CONTACT LENS EVALUATION (AND TRAINING IF NEEDED)
- □ CONTACTS

By marking the boxes above you are giving permission to ARLINGTON VISION CENTER to provide the above services and eyewear.