



## CONSENT TO TREAT MINOR CHILDREN

I, \_\_\_\_\_, the undersigned parent/legal guardian of \_\_\_\_\_, whose date of birth is \_\_\_\_\_, do hereby give my consent to Dr. Henry and the staff of Henry Vision Center to examine and administer treatments, as they do deem necessary, to the above named individual. I understand that I am responsible for the charges for the goods and services provided. I am aware that I am able to revoke this authorization at any time by written correspondence to Henry Vision Center.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent or Legal Guardian