Downtown • 120 SE Fourth St., Ste. 1300 • Evansville, IN 47708
Gateway Health Center • 4233 Gateway Blvd. • Newburgh, IN 47630

Consent to Treat Minor Children

I, ________________________, parent and/or legal guardian of ________________________,

born on __________________________ do hereby consent to any medical eye care determined by a physician to be necessary for the welfare of my child at The Vision Care Center. I also understand that the exam fees and fees to purchase glasses and contacts are not always fully covered by insurance. I am responsible for paying those fees to The Vision Care Center.

____ ______________________
Signature of Parent or Legal Guardian Date

Family Address ____

Primary Phone Number ___________________ Daytime Phone Number ___________________

Individuals that I give consent to attend and assist in my child's eye appointment:

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