Dr. J. G. Agnew
Dr. P.G. Chapman
Dr. R.A. Christiuk
Dr. S.T. Thom

25B Main Street South
Kenora, Ontario
P9N 1S8
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OPTOMETRY CONSENT FORM

CONSENT TO TREAT MINOR

Patient's Name: ____

Date of Birth: ____

Status #: ____

Health Card: ____

Medications: ____

Allergies: ____

Health Conditions: ______________________________________

Other Pertinent Information: ____________________________

I, ____, the parent or legal guardian of ____ authorize DR. SIERRA THOM and DR. RORKE CHRISTIUK (OPTOMETRISTS) to evaluate and treat him/her/them without my presence. I consent to any medical and/or routine vision care as determined to be necessary for the welfare of my child and their eyes/vision in my absence. This includes but is not limited to:

- a comprehensive eye exam
- use of my signature for Non-Insured Health Benefits program if my child requires glasses
- referral to an ophthalmologist in either Thunder Bay or Winnipeg if medically necessary

This document is effective as of the date written below and will remain in effect until the patient reaches eighteen years of age.

Name: ________________________________ Date: ______________________________

Signature: ____