



FRENCH
EYE CARE
CENTER PLLC

P.O. Box 852
103 Roosevelt Blvd., Suite C
Eleanor, WV 25070

Parental Consent Form

I consent for my child, _____ to be
(please check all that apply)

- dilated
- fit for contact lenses
- treated as deemed medically necessary

by the examining doctor at French Eye Care Center.

on _____.(date of appointment)

Signed _____(parent or legal guardian)

I have read and signed the **Financial Agreement** provided stating I agree with the financial policies of French Eye Care Center, PLLC.

Signed by _____ Date ____ / ____ / ____

Patient / Parent / Guardian / Medical Power of Attorney

Please circle appropriate title