AUTHORIZATION TO EXAMINE MINORS

By my signature below, permission is given to Dr. J. Ellis Cosby to examine (patient's name)_____. This examination will include refraction for glasses and/or contact lenses as needed. Also included will be an ocular health examination that may include dilation.

Parent or guardian: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Permission to dilate today:

Parent or guardian: _____ Date: _____

Parent or guardian: _____ Date: _____

Parent or guardian: _____ Date: _____

Parent or guardian: _____ Date: _____

Parent or guardian: _____ Date: _____

Parent or guardian: _____ Date: _____

Parent or guardian: _____ Date: _____