___/___/____

EYEZONE

To Whom It May Concern:

I, _____ , will not be able to attend the appointment for my child, _____, on ___/___/____.

I, _____, give EyeZone permission to see my child without me being present.

Please initial the services that you are authorizing EyeZone to perform on your child.

The services I authorize are:

[ ] **Eye Exam**

[ ] Retinal Photography Screening- I understand that I am responsible for the $19 fee associated with this test, before my child is seen.

[ ] Dilated Exam

[ ] **Contact Lens Exam**

- My child has worn contact lenses before. I understand that I am responsible for the $40 contact evaluation fee, before my child is seen.

[ ] **Contact Lens Exam**

- My child will need the Insertion & Removal Training, as he/she has never worn them before. I understand that I am responsible for the $95 fee for the Insertion & Removal Training, before my child is seen.

_____
Child/Minor's Printed Name

_____ _____ _____
Parent/Guardian Printed Name Parent/Guardian Signature Date