CONSENT TO TREAT MINOR CHILDREN

I, _____, the undersigned parent/legal guardian of _____, whose date of birth is ___/___/_____, do hereby give my consent to Dr. Henry and the staff of Henry Vision Center to examine and administer treatments, as they do deem necessary, to the above named individual. I understand that I am responsible for the charges for the goods and services provided. I am aware that I am able to revoke this authorization at any time by written correspondence to Henry Vision Center.

X _____

Signature of Parent/Legal Guardian

Date: ____/____/_____