EYE PHYSICIANS OF CENTRAL FLORIDA
A division of Florida Pediatric Associates, LLC

PARENT/ GUARDIAN PERMISSION LIST

I, _____, give permission for the following individual(s)
(*Print* Parent or Guardian Name)

_____

_____

_____

_____

_____

_____

to bring my child for treatment and examination and make medical decisions on my behalf.

_____
Print Child's Name

I understand the individual(s) listed above must be 18 years of age or older and provide a picture ID at the appointment. Permission will remain in effect unless revoked by me in writing.

_____ _____
Signature of Parent/ Guardian Date

_____
Print Name of Parent/Guardian