Brennan Eye Care

Dr. J. Patrick Brennan
Dr. Christine V. Brennan
710 S. Parrott Avenue
Okeechobee, Fl. 34974
Ph. (863) 467-0595
Fax (863) 467-1686

Consent for Treatment

If your child is a minor, please fill out the information below:

Name of Parent/Legal Guardian:____
Social Security #_____/_____/_____ Date of Birth_____/_____/_____
Home Phone (_____)__________________ Work Phone (_____)______________________
Address____
City______________________________ State___________ Zip___________

I, _________________________________, being the parent or legal guardian of _________________________________, am authorized and hereby give permission to the medical staff of **Dr. J. Patrick Brennan** and/or **Dr.Christine V. Brennan**, to perform any opthalmic examination and/or treatment necessary to his/her care. In the event of complications, I further authorize the medical staff to administer any emergency treatment necessary.

___________________________________ ________________________

Signature Date