



Dr. Elaina M. Groo
Optometrist
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PARENT CONSENT FORM

Child's Name: _____ D.O.B. ___/___/___

Parent's Name: _____

Parent's daytime contact number: _____

I hereby give my consent to the office of Dr. Elaina M. Groo, Optometrist to examine _____ and fit contact lenses in her office without my presence.

I understand all fees related to the contact lens fitting are payable at the time of the fitting.

_____ I will send a check with my child for the amount due.

_____ I will pay the amount due by Credit Card.

Credit Card Number _____

Expiration date: _____ Security code (on back of card) _____

Parent / Guardian's Signature: _____

Date Signed: _____