NISWANDER EYE CENTER

40 NORTH UNION ROAD
WILLIAMSVILLE NY 14221
PHONE (716) 634-4441
FAX (716) 634-3174

AUTHORIZATION TO EXAMINE CHILD UNDER 18 YEARS OF AGE

I, _____, authorize Niswander Eye Center
(Print name of parent or guardian)
to examine my child, _____, to include dilation of the
(Print name of child)
pupils.

_____ _____
Signature of parent or guardian Date