

**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