

## Informed Consent for Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person. They may also make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Driving may be difficult immediately after an examination, so it is best if you make arrangements not to drive yourself when you leave our office. If your child is dilated, he/she will have difficulty in completing schoolwork and homework. In addition, he/she should not participate in contact sports on the day of dilation.

I hereby authorize the doctors at Eye Surgery Associates and/or such assistants as may be designated by them to administer dilating drops. I understand that eye drops are necessary to diagnose my condition and/or to examine my eyes and that dilating drops may be put into my eyes each time I am examined or treated at Eye Surgery Associates' offices.

\_\_\_\_\_  
Patient (or person authorized to sign for patient)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## CONSENT FOR MINOR OR INCOMPETENT

If the patient is unable to sign, or is a minor, complete the following:

Patient is a minor \_\_\_\_\_ years of age.

Patient is unable to sign because \_\_\_\_\_.

\_\_\_\_\_  
Signature of Closest Relative or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date