Steven R. Bullard, M.D.
703-370-2455

I give permission for my child to be examined in my absence by Dr. Steven Bullard. I understand that it is standard and necessary to dilate the eyes for a complete eye exam and give Dr. Bullard permission to dilate my child's eyes. I understand if the eyes are dilated they will be blurry and that sunglasses (provided by Dr. Bullard) may be needed for comfort in sunlight for about 8 hours.

My child will be accompanied by the following adult: ____

My child can be accompanied by this adult: ___Any time

___Limited to following date(s):_____________

I give permission for Dr. Bullard to discuss my child's exam, diagnoses, and treatment with the adult who is accompanying my child.

______________________________________ ___________________________
Child's Name Child's Date of Birth

______________________________________ ___________________________
Parent/Legal Guardian Signature Date

____
Printed Name of Parent/Legal Guardian

____
Phone number where parent/guardian can be reached