City and County of San Francisco
Juvenile Probation Department

University of California at Berkeley
School of Optometry

Juvenile Probation Department / UC Berkeley School of Optometry Vision Testing Program

Parental/Guardian Consent & Referral Form*

Patient Name___________________________________ **Age**________ **D.O.B.**________ **PFN#**_________

Address_____________________________**City**__________________**State**__________**Zip**______________

Name of Parent/Guardian__________________________________ **Tel.#** ___________________

Address of Parent/Guardian________________________________**City**_______________**State**________**Zip**________

Insurance ____**No** ____**Yes** (If Yes) **Name of Insurance Carrier** _______________________________
Insurance I.D.#____________________

Medi-Cal # (if applicable) ________________________

Reason for Testing ____
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Parental/Guardian Authorization Required
As parent/guardian of the above juvenile patient, I authorize the San Francisco Juvenile Probation Department to: release this patient information to the Berkeley School of Optometry; to transport my child to the Berkeley School of Optometry Clinic in Berkeley; and authorize my child's vision examination at this Clinic, in accordance with this Vision Testing Program.

____ _______________
Parent's or Guardian's Signature Date

Referring PO: ______________________**Court Officer Unit Supervisor:**________________

Appointment Date: _______________________________

***Completed Form Must Accompany Each Patient to the Clinic**