Myopia Control Consent Form

_____ I understand that using atropine and soft multifocal contact lenses for myopia control (slowing the progression of nearsightedness) can be an off-label use.

_____ The details of the treatment including expected benefits, risk and alternatives have been explained to me in terms I understand.

_____ I understand that there are no guarantees about the results of the treatment.

_____ I understand that there may be unknown risks and that the long-term effects and risks are

not known.

_____ I understand that there is no guarantee or assurance of any treatment outcome for my child and that these treatments may not slow the progression of nearsightedness.

_____ I wish to have my child prescribed the following option for myopia control:

- o Atropine, 0.05%, 0.025%, or 0.01%
- o MiSight Contact lenses
- o Biofinity Multifocal Contact Lenses

I have read and understand this treatment agreement.

Child's name: _____ Child's date of birth:_____

Parent/Guardian: _____ _____ _____

Printed name Signature Date

I have explained the treatment, purpose, and expected benefits and risks to the patient/parent-guardian and answered any questions to the best of my knowledge.

Doctor: _____ _____ _____

Printed name Signature Date