Child Assent Document

I am being fitted with gas permeable (GP) contact lenses, also known as Corneal Refractive Therapy. These contact lenses reshape the cornea (the clear layer on the front of the eye) for a short time, which allows me to see clearly without the use of glasses or contact lenses while I am awake The Corneal Refractive Therapy contact lenses must be worn on a regular basis during sleep so that I can see clearly during the day without glasses or contact lenses.

It is important that I agree to the following guidelines to keep my eyes healthy and allow me to wear contact lenses. Place a checkmark in each box if you agree.

- ☐ I agree to wear my lenses no more than _____ hours per night.
- ☐ I agree to wash my hands before inserting or removing my contact lenses
- ☐ I agree to clean my lenses according to my doctor's instructions each time I remove them
- ☐ I agree not to rinse my contact lenses in water from the sink. I will only use contact lens solutions to rinse my contact lenses
- ☐ I agree to tell my parents or my doctor immediately if my contact lenses irritate my eyes
- ☐ I agree to tell my parents or my doctor immediately if my eyes appear red or are painful.

I understand that if I do not do the things listed above, my eyes may get hurt or I may not be able to wear my contact lenses.

Child's Name _____ Child's Age: _____

Child's Signature: _____ Date: _____