DR SHANTIR'S PRACTICE

CONSENT FOR TREATMENT OF A CHILD UNDER THE AGE OF 16 YEARS BROUGHT TO THE SURGERY ON BEHALF OF PARENT/ GUARDIAN / PERSON WITH LEGAL PARENTAL RESPONSIBILITY

Patient details:

Surname ……..

First names ……..

Date of birth …….. Male/Female ……

Allergies (please √): ☐ None ☐ Please list

I am the *Parent / Guardian / Person with Legal Parental Responsibility for the above named patient and hereby consent to the following person bringing them to Dr Shantir's Practice for (Please √) :

Review ☐

Treatment ☐

Vaccinations ☐

Name: …….. Relationship …….
(Person bringing the child to surgery)

Signed ……. (Print Name)……
*Parent / Guardian / Person with Legal Parental responsibility

* Delete as applicable Date: ……

PLEASE NOTE:

A NEW FORM IS REQUIRED <u>EACH TIME</u> YOUR CHILD IS SEEN