Forest Road Medical Centre
354-358 Forest Road
London E17 5JL
Telephone Number: 020 8520 7115

Dr Shantir's Practice
Waltham Forest Primary Care Trust

TREATMENT FOR CONSENT FOR A CHILD UNDER THE AGE OF 16

I, the;

Parent ☐
Guardian ☐

Give consent for treatment of _____ under the age of 16 years brought to the surgery on _____2018 , on the behalf of parent/ guardian / person with legal parental responsibility

PATIENT DETAILS:

Surname _____
First names _____
Date of birth _____ Male ☐ Female ☐
Allergies (please √): None ☐ Please list _____
_____
_____
_____
_____
_____
_____

Parent ☐ Guardian ☐

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