



First visit child treatment consent form

To be completed by parent/guardian for patients up to 16 years of age before the first consultation at the clinic.

Patient Information

The child whose name and details are entered below will hereafter be known as "The Patient" throughout this document.

First name	<input type="text"/>	Surname	<input type="text"/>
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of birth (dd/mm/yyyy)	<input type="text"/>

Address	<input type="text"/>		
	<input type="text"/>	Post code	<input type="text"/>

- I, (full name of parent/guardian)
- Mr
 - Mrs
 - Ms
 - Miss
 - _____

First name	<input type="text"/>	Surname	<input type="text"/>
of (Address, if different from above)	<input type="text"/>		
	<input type="text"/>	(Post code)	<input type="text"/>

(Parent/guardian telephone number)	<input type="text"/>	(Email)	<input type="text"/>
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being the (relationship to The Patient)	<input type="text"/>		
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consent to The Patient undergoing consultation, examination, clinical tests and treatments, including administration of medication, the nature and effect of which will be explained to me by a healthcare professional at Breakspear Medical Group.

I also consent to undergoing testing and treatment including administration of medications. I understand that some of the medicines administered are classed as "Specials" by the Medicines and Healthcare products Regulatory Authority and are not licensed medicines in the UK. The implications of this and any possible risks or side effects will be fully explained to me prior to administration.

I agree to accompany The Patient at all times while he/she is attending Breakspear Medical Group. I understand that there is no guarantee that the procedures will be carried out by a particular member of the clinical staff.

I understand that if I have chosen to provide my email address to Breakspear Medical Group that Breakspear Medical Group may use this method of communication to contact me. I understand that email transmission cannot be guaranteed to be secure or error-free and therefore Breakspear Medical Group does not accept liability for any errors or omissions in the contents of messages, which arise as a result of email transmission.

Tick one of the following boxes:

- I agree that information from Breakspear Medical Group can be sent to The Patient's GP.

Name of GP	<input type="text"/>
Address	<input type="text"/>
Telephone number	<input type="text"/>

- I do not agree that information from Breakspear Medical Group can be sent to The Patient's GP.

The Patient's signature (when appropriate)	<input type="text"/>	Date	<input type="text"/>
Parent/guardian's signature	<input type="text"/>	Date	<input type="text"/>

If the above is not the mother, biological father married to the mother, legal guardian or does not have Parental Responsibility, a signed letter of authorisation is required from one of the above people.

Consent to procedures is recorded in line with the Department of Health Guidance 'Reference Guidance to Consent for Examination or Treatment'.

1. It is optional to provide your email address.