



Livingstone Street Clinic

MEDICAL CONSENT FORM FOR A MINOR

This document is used by parents or legal guardians to grant another person the authority to make medical decisions for their child when they are not present. For patients under the age of 16 years.

Child's Information:

Full Name: _____

Date of Birth: _____

Parent or Legal Guardian Information:

Name: _____

Contact details: _____

Caregiver's Information:

Name: _____

Contact Details: _____

Relationship to the child of the person authorized to make medical decisions:

Consent for Specific Treatments. Please tick the boxes you consent to:

- Examination
- Bring my child to medical appointments
- Provide a history of my child's symptoms
- Receive and discuss test results and management of advice and pass on advice to parents
- Consent to minor procedures (e.g. swabs, ear syringing)
- Consent to prescriptions for minor conditions (e.g. paracetamol, antibiotics for URTI, finger prick test and urinalysis)
- Consent to vaccinations (please specify which, if applicable): _____
- Be contacted in place of parent during working hours if child is unwell
- Other: _____

I do not authorise the carer to: _____

Duration of Authority: Specify the period for which the caregiver's authority is valid:

Signed: _____ Name: _____ Date: _____