**Parent’s permission for Surrey Childrens Services to accommodate their child(ren).**

This agreement is between Surrey Childrens Service and

Mother :- (parent(s) name)

Father :- (parent(s) name)

(Does the father have Parental Responsibility?

I agree to Surrey Children’s Services accommodating my child under Section 20 of the Children Act 1989. I understand this is a voluntary agreement and agree to work with Surrey Children’s Services in plans for my child. I understand that I can withdraw my consent at any time.

Child 1:

Child 2:

I also give permission for the carers/Surrey Children’s Services to seek emergency medical advice, treatment and examinations if needed. I understand that we will be notified if this takes place.

**Signed**

Mother .................................................. Date.................

Father ..................................................... Date.................

Social worker ................................................... Date ..................

**Health consents**

**Consent for Statutory health assessments, routine medical treatment and referrals**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Child** | **Date of Birth** | **NHS Number (if known)** | **LCS Number** |
|  |  |  |  |

**Name of Person(s) with Parental Responsibility**

|  |
| --- |
| Name: |
| Name: |

All children and young people ‘looked after’ by the Local Authority should have their health needs assessed regularly by a registered health professional. The purpose of Health Assessments is to ensure any health needs are identified and met to inform your child’s care plan. This information will be shared with parents and carers, social worker, GP, and other health professionals involved in your child’s care. After the first assessment, your child’s health is then regularly reviewed by a registered health professional (every 6 months if your child is under 5 years old and every 12 months if your child is over 5 years old). Consent has been explained to me and I agree to the following:-

|  |  |  |
| --- | --- | --- |
| Please tick relevant column | YES | NO |
| I consent to my child having his/her health needs assessed as soon as he/she is placed in care and assessed 6 monthly/annually thereafter |  |  |
| I consent to his/her health records being accessed and disclosed to relevant people |  |  |
| Routine medical treatment [excluding all procedures involving general anaesthetic] |  |  |
| Routine Immunisations [this will include the MMR vaccination] |  |  |
| Routine dental treatment [excluding all treatment involving general anaesthetic] |  |  |
| Arranging registration with an optician and routine optical assessment |  |  |
| Referrals to other health services as recommended if it is in the best interests of my child, for example Audiology, Speech and Language Therapy, Child and Adolescent mental health Services |  |  |

My consent is given on the understanding that:

1. all information will be treated as confidential and only shared with other professionals as appropriate;
2. my consent will be considered valid unless specifically withdrawn (preferably in writing);
3. I have the opportunity to review my consent at Looked After Child review meetings;
4. Where any referrals recommend treatment by a medical practitioner other than a GP I will be notified.
5. I understand ‘relevant people’ to mean:-
6. Health and education professionals looking after and assessing my child;
7. Doctors and nursing advising the agencies involved in my child’s care;
8. Social workers and local authority professionals planning my child’s care;
9. Any professional acting in furtherance of the protection of children;
10. My child’s carers;
11. My child at suitable times in the future.

**Signed by person (s) with parental responsibility**

|  |  |
| --- | --- |
| Print Name: | Signature |
| Relationship to Child: | Date |
| Print Name: | Signature |
| Relationship to child: | Date: |

**Signed by Child or Young Person (able to consent)**

|  |  |  |
| --- | --- | --- |
| Print Name: | Signature | Date: |

**Witnessed By Social Worker/Assistant Team Manager /Team Manager**

|  |  |  |
| --- | --- | --- |
| Print Name: | Signature | Date: |

**Signed By Social Worker/Assistant Team Manager /Team Manager where no parental responsibility**

|  |  |  |
| --- | --- | --- |
| Print Name: | Signature | Date: |

**Consent to obtain and share medical information relevant to your child whilst he/she is in the care of the Local Authority**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Child** | **Date of Birth** | **NHS Number (if known)** | **LCS Number** |
|  |  |  |  |

**Name(s)of birth parents**

|  |
| --- |
| Name: |
| Name: |

I understand that it is important to the welfare of my child that professionals are able to access my medical records and those of my child.

1. On this basis I consent to information being disclosed to relevant people:-
2. My child’s health history including pregnancy and birth information;
3. My own health information
4. Information relating to significant health problems within my family
5. I understand ‘relevant people’ to mean:-
6. Health and education professionals looking after and assessing my child;
7. Doctors and nursing advising the agencies involved in my child’s care;
8. Social workers and local authority professionals planning my child’s care;
9. Any professional acting in furtherance of the protection of children;
10. My child’s carers
11. My child at suitable times in the future.
12. My consent is given on the understanding that:
13. all information will be treated as confidential and only shared with relevant people as appropriate;
14. my consent will be considered valid unless specifically withdrawn (preferably in writing);

**Signed by Birth parent(s)**

|  |  |
| --- | --- |
| Print Name: | Signature |
| Relationship to Child: | Date |
| Print Name: | Signature |
| Relationship to child: | Date: |

**Witnessed By Social Worker/Assistant Team Manager/Team Manager**

|  |  |  |
| --- | --- | --- |
| Print Name: | Signature | Date: |