**Children Act 1989 – Private Fostering**

 **PF9 - Healthcare Authorisation**

|  |  |
| --- | --- |
| **Name of child** |  |
| **Address** |  |
|  |  |
| **Date of birth** |  |
| **Parents name** |  |
| **Address** |  |
|  |  |

I, the undersigned, being the mother/father/person (delete as appropriate) with parental responsibility of the above named child authorise the carer;

|  |  |
| --- | --- |
| **Name of Carer** |  |
| **Address** |  |
|  |  |

to consent on my behalf to:-

1) Medical examination

2) Non-emergency medical or operative treatment

3) Emergency operation or treatment

4) Administration of a general anaesthetic

5) Dental treatment

6) To appropriate immunisation

I understand that whenever possible I will be informed where treatment or medical attention is required

|  |  |
| --- | --- |
| **Print Name** |  |
| **Signed** |  |
| **Date** |  |