**WOODLAND MEDICAL PRACTICE**



**Parental Consent Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Father’s Name** |  | **Date** |  |

|  |  |
| --- | --- |
| **Mother’s Name** |  |

|  |  |
| --- | --- |
| **Address** |  |

**We parents of……………………………………………………………. (Child’s Name)**

**do hereby give our consent to……………………………………………………(Name of relative/friend (please ALSO, specify relationship status to child) to deal with medical matters relating to the above child on our behalf.**

|  |  |
| --- | --- |
| **Father’s Name and Signature** |  |

|  |  |
| --- | --- |
| **Mother’s Name and Signature** |  |

|  |  |
| --- | --- |
| **Relative/friend’s Signature** |  |

|  |  |
| --- | --- |
| **Date** |  |

**Please hand to reception**

**A copy will be scanned onto relevant patient’s records**