**PARENTAL AGREEMENT FOR A CHILD OR YOUNG PERSON TO VISIT A PATIENT**

**AT REASIDE CLINIC/TAMARIND CENTRE**

|  |  |  |
| --- | --- | --- |
| **I, (Title)** | **(Mr, Mrs, Ms, Miss etc)** | |
| **Full Name of Parent/Guardian:** |  |  |
| **Full Address:** |  |  |
|  |  |  |
|  |  |  |
| **Telephone or Mobile Number:** |  |  |

**Give my consent for**

|  |  |  |
| --- | --- | --- |
| **Full Name of Child:** |  | |
| **DOB of Child:** |  | |
| **Full Address of Child:** |  | |
|  |  | |
|  |  | |
| **To Visit (name of patient at Reaside Clinic/Tamarind Centre):** | |  |

**Does the child have any special requirements which we need to take into consideration? YES/NO**

**If YES please specify:**

**Has the child ever lived outside of the Birmingham City Council area?**

**YES/NO**

**If YES, please provide further detalils:**

I confirm that I am the MOTHER/FATHER/LEGAL GUARDIAN/OTHER RELATION (please specify):

|  |  |
| --- | --- |
|  | **Of the child** |

I undertake to be responsible for the child throughout their visit to the unit and will remain with them while they are on hospital premises

**OR**

|  |  |  |
| --- | --- | --- |
| **I nominate (Title)** |  | **(Mr, Mrs, Ms, Miss etc)** |
| **Full Name of Parent/Guardian:** |  |  |
| **Full Address:** |  |  |
|  |  |  |
|  |  |  |
| **Telephone:** |  |  |

To exercise responsibility for the child while they are on hospital premises and to remain with them throughout their visit.

**Their relationship with the child is (please specify):**

|  |
| --- |
|  |

**The relationship of the child with the patient is (please specify):**

|  |
| --- |
|  |

I understand that, in addition to my agreement, the visit will be granted at the discretion of the clinical team with responsibility for the care of the patient and that of the senior nurse on duty at the time of the visit.

I undertake to give the ward having care of the patient not less than 48 hours’ notice of any visit.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please tick the box to indicate you do not wish any information on this form to be available to the patient:** | | | |  |
| **Signed:** |  | **Date:** |  | |
| **Print Name:** |  |  | | |

**PLEASE RETURN THIS COMPLETED FORM TO SOCIAL WORK DEPARTMENT, REASIDE CLINIC COMMUNITY SERVICE BUILDING, REASIDE DRIVE, RUBERY, BIRMINGHAM, B45 9BE**