**REASIDE CLINIC/TAMARIND CENTRE**

**REQUEST FOR APPROVAL OF CHILD VISITOR**

**PATIENT DETAILS**

|  |  |
| --- | --- |
| **Name:** |  |
| **RC:** |  |
| **Relationship to Child:** |  |

**CHILD DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** | |  | |
| **Gender:** |  | **DOB:** |  |
| **Full Address:** | |  | |
|  | |  | |
|  | |  | |
| **Post Code:** | |  | |
| **Local Authority (Name):** | |  | |
| **Accommodated, subject to care or supervision order, or other statutory involvement?** | |  | |

**RESPONSIBLE PARENT OR GUARDIAN (i.e. Current carer, not patient)**

|  |  |
| --- | --- |
| **Full Name:** |  |
| **Full Address:** |  |
|  |  |
|  |  |
| **Post Code:** |  |
| **Relationship to Child:** |  |
| **Relationship to Patient:** |  |

I give my permission for the clinical team to contact the person or persons having parental responsibility for the above named child to obtain their consent to that child visiting me at Reaside Clinic/Tamarind Centre.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients Signature:** |  | **Date:** |  |