NHS

TheMKWay
CARE COMMUNICATE
COUAEORßTE. CONTRIBUTE.

Milton Keynes
University Hospital
NHS Foundation Trust

Surname	_____
First Name	_____
D.O.B	_____
Hospital No	_____

Or affix patient label

Paediatric Physiotherapy Team School Consent Form

Child's name-.....

Name of Parents/Guardians•.....

Daytime Telephone Number.....

Home Telephone Number.....

School/Nursery•.....

I give consent for my child _____ to be assessed and treated by the Physiotherapist(s) according to the guidelines for good practice set by the Health Care Professions Council.

I do / do not give permission for my child to be seen in school and / or for their condition to be discussed, as appropriate with school staff.

Child Signature (where appropriate)'.....

Parent/Guardians Signature•.....

Name (Printed)'.....

Date-.....

Physiotherapists Signature•.....

Name (Printed)'.....

Date•.....