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| **On-going Delegated Consent for Kent County Council (KCC) to arrange routine statutory holistic health assessments, routine check-ups for dental and optical assessments and routine vaccinations as per schedule for the child/young person named below whilst s/he is looked after by them, if the child/young person is not deemed able to give his or her own consent to an appropriately qualified medical practitioner.** |

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| **Consent** | | | | | |
| **I/We, who have parental responsibilities for** | | | | | |
| **(child/young person)** | | *Full name of child* | | | |
| **Agree to** | | | | | |
| **Type of treatment:** | | | | | |
| **Consent to carry out Statutory Initial and Review Health Assessment and to act on the recommendations of the Health Action Plan, this includes referral to universal services and targeted services such as Speech & Language and CAMHs and share relevant information with other professionals.**  **Additional information and consent will be sought for any investigations and/or referrals deemed necessary by doctors undertaking the health assessment that may have implications for the wider birth family such as genetic testing and blood born virus testing.** | | | | | |
| **Delegated consent to the above will rest with the Director of children’s Services in Kent County Council.** | | | | | |
| **Consent Form** | | | | | |
| **Agreement to on-going delegated consent. *(On-going consent means the consent given today will remain in force until such time as this is withdrawn in writing by the person with parental responsibility or the child reaches 18 years of age)***  On-going consent has been fully explained to me and I have fully understood the implication of this. | | | | | |
| **I have parental responsibility and on behalf of my child, I give my consent to ongoing delegated consent (not necessary if child/young person able to consent)**  **Name:**  **Relationship to Child:** | | | | | |
| **Signature**: |  | | | **Date:** |  |
| **I agree to the information gained at routine health monitoring being shared with Social Worker, GP and LAC Health Team.**  **If further information is required I give consent for the agency Health Adviser to obtain information.** | | | | | |
| **Consent regarding child's health information**  **I have parental responsibility and on behalf of my child, I give my consent to access my child's health information (not necessary if child/young person able to consent)** | | | | | |
| **Signature:** |  | | | **Date** |  |
| Witness (required for one or both signatures above)  Name (please print):  Address: | | | | | |
| **Signature of witness:** | | |  | | |
| **Name of Social Worker completing the form:** | | |  | **Date** |  |
| **Signature:** | | |
| **Name of Manager:** | | |  | **Date** |  |
| **Signature:** | | |  | | |
| **Date Record completed:** | | |  | | |

**Note:** This consent form becomes invalid if the parent gives notice to Social Care that they intend to remove their agreement for their child to be accommodated under a Section 20 agreement. It is the Social Workers responsibility to inform health if the parent gives notice to end the Section 20 agreement.