

Consent to Placement and Medical Treatment

Consent to placement

I / We, who have parental responsibility for _____

agree to Central Bedfordshire Council council looking after my child _____ under Section 20 (CA89)

understand that my child _____ is being looked after under Section _____

I / We, who have parental responsibility for _____ understand that I / we will receive a copy of the Placement Plan for _____ within _____ days

Consent to medical treatment

I / We who have parental responsibility for _____ agree to Central Bedfordshire Council arranging the following surgical, medical and dental procedures or treatments for the above named child / young person whilst s/he is looked after by them, if the child / young person is not deemed able to give his or her own consent by an appropriately qualified medical practitioner

Type of treatment

Consent given for emergency surgical, medical and dental examinations and intervention (including anaesthetics)

Yes

No

Name and position of the person to whom the authority has delegated the responsibility for giving consent to medical treatment

Consent given for routine medical and dental intervention / treatment deemed by an appropriately qualified medical practitioner to be in the best interests of the child / young person (including immunisations)

Yes

No

Name and position of the person to whom the authority has delegated the responsibility for giving consent to medical treatment

Consent given for planned surgical intervention / treatment deemed by an appropriately qualified medical practitioner to be in the best interests of the child / young person

Yes No

Name and position of the person to whom the authority has delegated the responsibility for giving consent to medical treatment

Consent given for administration of non prescriptive over the counter medication

Yes No

Name and position of the person to whom the authority has delegated the responsibility for giving consent to medical treatment

The issue of consent to medical treatment has been explained to me

Yes No

Parent / carer comments

Additional agreements

| Additional agreement, please specify | Parental consent |
|--------------------------------------|------------------|
| | |

Parents' / Carers' signatures

Signature of parent(s) or those with parental responsibility

Parent / Carer 1

Signature

Name

Designation

Date

Parent / Carer 2

Signature

Name

Designation

Date

Arrangements for delegation and exercise of responsibility for consent to medical and dental examination or treatment