

**CHILD CONSENT FORM
FOR TREATMENT AT WHOLISTIC MEDICAL CENTRE**

(For children under 16 years of age)

I.....am the parent/guardian of
.....and consent to his/her treatment by
Wholistic Medical Centre Ltd.

I sought treatment from Dr Shamim Daya for medical problems of my child which have previously been evaluated and treated by the appropriate experts. I am willing to consider unconventional approaches of functional medicine to help support my health.

I understand that some of the investigations, treatments and protocols Dr Shamim Daya recommends may not be supported by the medical literature of a kind generally required by accepted medical practice, but instead by clinical judgement and experience, case reports, and in some instances by my personal preferences.

I undertake to provide Dr Daya and her team with information on other medication, supplements and treatments being taken, on an ongoing basis, in case of contra indications or conflict with the planned treatment programme.

I understand that I shall receive full disclosure of relevant information about the strengths, Weaknesses and risks of any treatments recommended.

I agree to notify Wholistic Medical Centre of any changes in my medical condition.

I do / do not wish my GP to be informed of this treatment.
(delete as appropriate)

Signed.....

Dated.....

Doctor

I declare that I have provided the above – named patient with explanations regarding the status and nature of this treatment to my best understanding and the patient signs this form and undergoes this treatment with informed consent.

Signed.....

Dated.....