|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| **Children’s and Young Person’s Continuing Care Consent Form**  (Adult with Parental Responsibility) | | | | | |
| **Name of Child/Young Person:** |  | | **DOB:** |  | |
| **Address:** |  | | **NHS No.** |  | |
| **Post Code:** |  | | **GP:** |  | |
| The person signing this form needs to have Parental Responsibility for the child or young person concerned. In cases where the child/young person is under the care of the local authority/foster care, please seek advice regarding who can consent and document clearly. This form can be used when a young person lacks capacity to consent. | | | | | |
| **Statement** | | | **Initials of Parent/Carer** | | **Initials Professional** |
| **I consent** to the Children’s Continuing Care Team gathering evidence about my child for the purpose of a Children and Young People’s Continuing Care Assessment. | | |  | |  |
| **I am aware** that information on my child is held electronically in accordance with the Data Protection Act 2018. | | |  | |  |
| **I understand** that this information, and the resulting assessment, will be shared with multidisciplinary colleagues from Health, Social Care and Education, as part of the Continuing Care Process, including providers who may deliver Heath and/or Social Care services to my child. | | |  | |  |
| *If there are any safeguarding concerns professionals are required to share information with all agencies regardless of permission given*. | | | | | |
| If a package of care is offered, **I agree** that information about my package can be included in my child’s Education, Health and Care Plan. | | |  | |  |
| **I understand** that this eligibility for Children’s Continuing Care is subject to review. | | |  | |  |
| **I understand** that any health care package is subject to review. | | |  | |  |
| **I understand** that I may withdraw my consent to share information at any time. | | |  | |  |
| However, **I do not want** the following information shared with: Please specify: | | |  | | |
| **Signature:** |  | **Printed Name:** |  | | |
| **Relationship to child:** |  | **Date:** |  | | |
| Please return this form to: BNSSG CCG Complex Care Team at:  Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group  E-Mail: [bnssg.cc.childrens@nhs.net](mailto:bnssg.cc.childrens@nhs.net) Tel: 0117 984 1656 | | | | | |