**APPENDIX 1**

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**PROXY online access for children under 11 years**

Child’s Full Name: ……………………………………………………………………………..

Child’s Date of Birth: …………………………………………………………………………..

Child’s Address: ……………………………………………………………………………….

**Information regarding access to online services:**

As a parent or guardian you have requested PROXY access to the above named child’s online account. In requesting this proxy access you will be able to do the following things on your child’s medical record:

Please tick services you are granting access to:-

✓

* Appointment booking
* Request medication
* Questionnaires
* Summary record access
* Detailed coded record access (see coded details of your consultation with any doctor or nurse at St Austell Healthcare)

**Details of the Parent/Guardian requesting PROXY access:**

Full Name: ………………………………………………………………………………..

Date of Birth: ……………………………………………………………………………..

Address: ………………………………………………………………………………….

Relationship: …………………………………………………………………………….

**Stopping access:**

Proxy access to your child’s account will be stopped on the day of their 11th birthday.

**Please sign below to confirm that you have read and understood the information on this form.**

Signature:………………………………………………… Date: …………………………….

*To be completed by SAH staff member:-*

*Type of photo ID Documentation seen for parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date seen \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_*

*Staff Members Initials \_\_\_\_\_\_\_\_\_\_*