

Child’s History and Consent Form

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| Your Name: | Child’s Name: |
| Child’s Date of Birth: | Contact Number: |
| Address: | |
| Email: | GP: |
| Emergency Contact (name and number): | |
| Current Medications (prescription, vitamins, herbs, supplements, antibiotics): | |
| Previous medications: | |
| Medical History (Accidents/Illness/Hospitalisation/Surgery): | |
| Allergies: | |
| What do you hope you gain from your visit to this practice? | |
| Is there anything else you’d wish to share? | |
| How did you hear about us? | |

**INFORMED CONSENT**

I understand that, when performed by a qualified practitioner, soft tissue therapy, mobilisations, myofascial release, assisted stretching, spinal adjustments and breath awareness are effective, safe methods of treatment for many conditions relating to the health and wellbeing of children and babies. I also understand that there may occasionally be some risk or adverse response to treatment. I do not expect the practitioner to be able to anticipate every possible, adverse response, but I wish to rely on the practitioner to exercise professional judgement during the course of the treatment for my child.

Name: Date: