SOUTH WEST
kids clinic

Liverpool Clinic
1/46 Rose St
Liverpool NSW 2170

Ph: 9602 3377
Fax: 9824 3769

Picton Clinic
9 Margaret St
Picton NSW 21571

Ph: 4677 1577
Fax: 4677 1575

CONSENT FOR THERAPY

I _____ give my permission for _____
Parent/Carer/Guardian's Name Child's Name

_____ / _____ / _____ to receive an assessment, management and therapy at the
Child's Date of Birth

discretion of the Therapist. I understand that this may involve some or all of the following:

(Please Circle)

Accepted therapeutic procedures, which *may* include: close physical contact for assessment & therapy	YES	NO
Exchange of information with the other relevant agencies, eg. GP, Paediatrician, school, specialist, allied health (OT, SP) etc via phone or written communication	YES	NO
Clinical photography and/or videotaping	YES	NO

* Please note that all records are held in the strictest confidence. Should you wish to do so, you can withdraw your consent at any time.

Signature: _____ ____ / ____ / ____
Parent/carer/guardian Date