LDC

Request to see the Doctor

the infants' home
CHILD & FAMILY SERVICES

Child Details

Name:	Date of Birth:
Program Area:	
Medicare Number:	Expiry Date:

Brief Description of Problem / Symptoms

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Consent / Authorisation

I am aware my child / infant will leave the licensed premises accompanied by a staff member to attend the clinic which is held within the grounds in Sylvester House in Meryl's office.

Do you wish to be contacted by the Doctor with the outcome? ☐ Yes ☐ No

_____ _____ _____

Parent Name | Parent Signature | Date

_____

Contact phone number for Doctor during the day

Privacy

The Infants' Home recognises that privacy is important to you and that we have a responsibility to protect any personal information you give us. In accordance with the Privacy Act. The information we collect from you will be handled sensitively and securely with proper regard for privacy.

Copies: ☐ HECC ☐ Original in child's file