Sláinte Leanaí Éireann
Children's Health Ireland

Consent Form for Patients Photographs

Full Name:
.....
Address: Addressograph
.....
HCR.....
.....

Today's Date:	***HcRN:***
Patient Name:	***Date of Birth:***
Patient Address:	

I understand that my own / my child's photograph may be taken as record in the course of my own / my child's assessment / treatment.

Please tick √

I agree to any photograph being used to teach other health professionals, provided that I am not / my child is not identified to them by name	
I do not agree to any photograph being used to teach other health professionals	

Name of Patient:	***Signature of Parent:***
Name of Parent:	***Signature of Patient:***
Witness Name:	***Witness Signature:***
Title:	***Date:***