**GRENOSIDE SURGERY and WADSLEY BRIDGE MEDICAL CENTRE**

[www.grenosidesurgery.com](http://www.grenosidesurgery.com) <https://patient.emisaccess.co.uk/>

**Access to GP Online Services for Children**

**(Children between 13 and 16 years of age)**

**Child’s Details**

|  |  |
| --- | --- |
| **Surname** |  |
| **First Name** |  | **Date of Birth** |
| **Date of birth** |  |
| **Address** |  |
| **Postcode** |  |
| **Email address** |  |
| **Telephone Number**  |  | **Mobile Number** |  |

I …………………………………………………………….……….(name of child) give permission for my GP Practice to give the following parent / guardian:

………………………………………………………………………….………………………….. proxy access to the Online Services identified in Section 2 below.

• I reserve the right to reverse any decision I make in granting proxy access at any time.

• I understand the risks of allowing someone else to have access to my health records.

• I have read and understood the information leaflet provided by the Practice.

|  |  |
| --- | --- |
| **Signature of Child:** | **Date:** |

**Services to be Accessed**

|  |  |  |
| --- | --- | --- |
| **1** | **Online Appointment Booking** |  |
| **2** | **Online Repeat Prescriptions** |  |
| **3** | **Immunisations & Allergies**  |  |
| **4** | **Coded Medical Record (optional)** |  |

**I agree with each statement (Please tick)**

|  |  |  |
| --- | --- | --- |
| **1** | **I will be responsible for the security that I see or download** |  |
| **2** | **I will not share this information with anyone else** |  |
| **3** | **I will contact the practice as soon as possible if I suspect that this account has been accessed by someone without my agreement** |  |

|  |  |
| --- | --- |
| **Name:** | **Date of Birth:** |
| **Signature:** | **Relationship to patient:** |
| **E-Mail address:** |  |

**THIS FORM MUST BE HANDED TO A MEMBER OF PRACTICE STAFF WHO WILL PRODUCE AN INDIVIDUAL ID TO ENABLE ON-LINE ACCESS**