Proxy Application for online access (Child Over 11 and under 16)

Name of Person for whom Proxy Access is being sought		
SURNAME		D.O.B
FIRST NAME		
ADDRESS		
EMAIL ADDRESS		
TELEPHONE NUMBER	MOBILE NUMBER	
I/We wish to have proxy access to the following online services (please tick all that apply)		
1. Booking appointments		
2. Requesting repeat prescriptions		
3. Receive Text Messages		
I/we wish to have access to book appointments and request repeat prescriptions. I/we will contact the practice as soon as possible if I/we suspect this proxy account has been accessed by someone else without my /our agreement. I/we know we can see the Trinity Medical Centre Privacy Notice on the website or in the waiting room.		
I/we are the parent/guardian/carer of the person named above		
Signature of parent/guardian (if joint parental responsibility then both parents are requested to give signed consent) Name: Signature:		Date
ADDRESS		
EMAIL ADDRESS		
TELEPHONE NUMBER	MOBILE NUMBER	
I/we give consent for the document to register for online services to be sent to the first parent's e-mail address shown on this form	Signature and date	
Signature of parent/guardian/Carer (if joint parental responsibility then both parents are requested to give signed consent) Name: Signature:		Date
ADDRESS		
EMAIL ADDRESS		
TELEPHONE NUMBER	MOBILE NUMBER	
I give consent for the document to register for online services to be sent to the first parent's e-mail address shown on this form.	Signature and date	
For office use only	Staff member to complete below	
Proof of ID given	Yes(please specify	
Identity Confirmed	Yes (please initial)	
On line registration documents printed/emailed and e-mail verified in patient's record	Print name and sign	