**Consent Form to Share Health Information**

Name of the child:

NHS number / DOB:

I agree that medical / health information held about my child by the:

School Nurse/ GP / Paediatrician / Consultant / Nurse Specialist

May be accessed and shared by the school nursing team for the Vulnerable Pupil Panel

------------------------------------------------------------Signature of child/ young person

(If appropriate)

-------------------------------------------------------------Signature of parent/ carer\*

------------------------------------Date