

Application for Parental/Guardian Proxy Access to Online Services

Parent/Guardian Details

Surname:	DoB:
First Name:	
Address:	
Email address:	
Telephone Number:	Mobile:
Do you already have a S1 online service Account of your own?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Child's Details	
Surname:	DoB:
First name:	
Address (if different from applicant)	
Your relationship to the patient:	

I wish to have proxy access to the following online services (please tick all that apply):	
1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>

I understand that this proxy access will cease automatically when the child reaches 11 years of age <input type="checkbox"/>	
Signature:	Date:

For Practice use only		
Patient NHS Number:	Practice computer ID number:	
Parent/Guardian	Date:	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Authorised by:		Date:
Date account created:		
Level of record access enabled:	Proxy Access <input type="checkbox"/>	Notes/explanation: