Viola Sampson BSc RCST BCST
contact@violasampson.com +44(0)7791 153183
www.violasampson.com

Written consent for craniosacral treatment of children and teenagers under 16 years old

For children and teenagers under 16 years old, I require written consent from their parent or someone who has parental responsibility. Consent is the process of you agreeing or giving permission for your child to have treatment. The consent process should include a joint discussion between you, me as the healthcare professional, and your child.

I want you and your child to have all the information you need to make a decision and feel you have made the right decision for them, so please ask any questions you both need to make that informed consent.

You can change your mind at any point after giving consent. If you do change your mind, I will ask you to also record this date in a written communication to me. Changing your mind will not affect my treatment of you or your child if you decide to resume treatment at any point in the future.

All information in this form will be retained in confidence and in accordance with GDPR guidelines.

Consent form

Child's full name			
Address			
Age of child		Date of birth	
Name(s) of parent/guardian attending and relationship(s) to child			
Your phone			
GP/Doctor name			
GP/Doctor phone			
Known medical conditions and medication			
Any other special needs requirements, directions, that would be helpful for Viola Sampson to know about			

I will inform Viola Sampson of any important changes to my child's health, medication or needs and also of any changes to our address or phone numbers provided.

I (or another parent/guardian) will remain in the room for the first session, and in any subsequent sessions, if that is requested by the child or Viola Sampson. I understand that Viola will never request me to leave the room. Only if my child clearly requests I remain outside the room for any subsequesnt session(s), I will remain in the waiting room and commit to staying within the building for the duration of the session(s).

The nature of the treatment has been explained to me and the fees involved. I have been made aware that Viola Sampson is committed to regular professional supervision and client confidentiality. I understand she is a fully registered member of the Craniosacral Therapy Association (CSTA) and is bound by CSTA's Code of Ethics in Practice.

I understand that Viola Sampson will keep session notes until 7 years after my child's 18th birthday, and that all notes and data are kept according to European GDPR data protection guidelines.

In the event of illness or injury, having parental responsibility for the above named child I give permission for emergency medical treatment to be administered where necessary by a nominated first aider, or by suitably qualified medical practitioners.

By signing below, I consent to my child attending craniosacral sessions and receiving craniosacral treatment by Viola Sampson RCST BCST. I have read and fully understood the above consent to treatment and certify that the form was submitted prior to treatment commencing.

Signature of Parent/Legal Guardian

Relationship to the child

Print Name Date

This consent form will remain valid until the child reaches their 16th birthday, or until consent is withdrawn.

Please return this form by post prior to the first session, or at the start of the first session (once you have had any remaining queries clarified) to:
Viola Sampson RCST, The Integrated Practice, 127 Harley Street, London W1G 6AZ.