ALLIED MEDICAL LIMITED

PO Box 302 250
North Harbour
Auckland
New Zealand

Freephone 0800 31 61 81 | Phone +64 9 415 1685

helpis@alliedmedical.co.nz

Seat Belt Buckle Guard Prescription

This form must be completed by a Health Professional in conjunction with Parent / Caregiver and sent to Allied Medical Ltd with the order for reference.

I request Allied Medical Ltd supply ___ (quantity required) Seat Beat Buckle Guard SOLELY USED by:

_____

(Name of client)

Address: _____

who is at risk of bodily injury while travelling in motor vehicles because **(Please tick ALL appropriate boxes)**:

☐ A behavioural disorder means that the client habitually release him/herself from the car safety restraint system.

☐ The client does not understand the need to remain restrained while travelling in a motor vehicle and constantly attempts to release him/herself.

☐ Other reason: _____

The client's Accredited Assessor or Specialist has issued a health certificate.
(A copy must be enclosed with this application) **(Please tick)**

I have read the enclosed information for health professionals prescribing the Seat Belt Buckle Guard. Copy of Medical Certificate and relevant documents will be kept in the vehicle, which the user travels in.	☐ Yes
Permission to use this device has been gained from the client's parent or guardian.	☐ Yes
All carers will follow the relevant protocols and regulations in the Restraint of Children with Disabilities in Motor Vehicles Guidelines – available on website documents tab.	☐ Yes
I understand that if anyone other than the legal guardian is using this device to restrain the client, they must have permission and instruction from the parents or guardian e.g. other carers, centre staff, taxi drivers etc.	☐ Yes

Signed: _____ Organisation: _____

Name of Prescriber: _____ Position:_____

Contact Phone No:_____ Email:_____

Parent / Caregiver signed: _____ Tel:_____

Name: _____ Date: _____