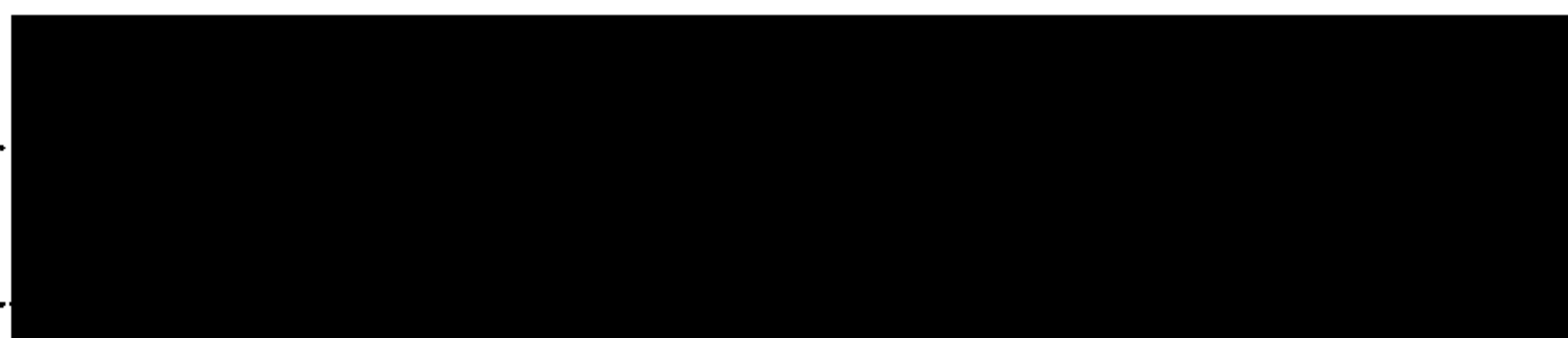


WMZ 7239

CONSENT BY PARENT OR GUARDIAN FORM II. OPERATIONS ON CHILDREN

EASTERN HEALTH & SOCIAL SERVICES BOARD
DISTRICT
RTHSC HOSPITAL

Patient's Name ADAM STRAIN
I DEBRA STRAIN of



the parent/guardian of the above-named, hereby consent to the
submission of my child to the operation of GASTROSCOPY

the nature and purpose of which have been explained to me by
DR./MR. W C. TOLLIN

I also consent to such further or alternative operative measures
as may be found to be necessary during the course of the
operation and to the administration of a general, local or other
anaesthetic for any of these purposes.

* No assurance has been given to me that the operation will be
performed by any particular surgeon.

Date 16/9/93 Signed Debra Strain
(Parent/Guardian)

I confirm that I have explained to the child's parent/guardian
the nature and purpose of this operation.

Date 16.9.93 Signed 055-005-007