New Patient Registration Form (*Children: under 16s*)

Instructions for completing this form on behalf of a Child

Date: …….

1. Complete a separate form for each child to be registered
2. Complete in BLOCK CAPITALS and tick the boxes and fill in each section as appropriate

1	**Full Name:**		**Telephone Number:**
	Title : **Master** ☐	**Miss** ☐	**Mobile tel. number:**
	Other. *Please state* **:**		
	NHS number if known:		We will use this to send appointment reminders and health promotion details. Please tick here if you do not wish to receive messages from us: ☐
	Address:		**E-mail address:**
			Next of Kin:
	Postcode:		
	How would like us to contact you about your child:		**Next of Kin Relationship to child:**
	Letter ☐ **Email** ☐		
	SMS (text) ☐ **Phone** ☐		**Next of Kin contact tel. number:**
	Date of Birth:	**Gender:** **Male** ☐ **Female** ☐	**Mothers name if different:**
	Town* and Country of birth (*If town is London please state which Borough)	**Country:** **Town:**	**Borough (*If born in London):**
	Please list other residents of your home who are registered with us:	**Name:**	**Date of Birth:**

2	**Looking after a family member**		
	Is your child looking after someone? Let us know if your child is looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems		Yes ☐ No ☐
	Is someone looking after your child? Let us know if a family member, friend or neighbour looks after your child.		Yes ☐ No ☐
	Carer's name:		
	Address of carer :		

	Telephone number of carer:

3	**Your Child's Religion** (Please tick)	C of E ☐	Catholic ☐	Other Christian (state): ☐	Buddhist ☐	Hindu ☐	Muslim ☐
		Sikh ☐	Jewish ☐	Jehovah's Witness ☐	No religion ☐	Other religion (state) ☐	
	Your Child's Ethnic Origin (Please tick one)	White (UK) ☐		White (Irish) ☐	White (Other) ☐		
	Black Caribbean / British ☐	Indian / British Indian ☐		Arabic ☐	Other Mixed Background ☐		
	Black African / British ☐	Pakistani / British Pakistani ☐		Chinese ☐	Other Asian Background ☐		
	Other Black Background ☐	Bangladeshi / British Bangladeshi ☐		Other ☐	Ethnic Category Refused ☐		
	What is your child's main spoken language?			**Does your child need an Interpreter?** Yes ☐ No ☐			
	Does your child need help with mobility/hearing/speaking? (tick all that apply)						
	Wheelchair ☐	Walking aid ☐		Hearing aid ☐	British sign language (BSL) ☐	Makaton sign language ☐	
	Lip reading: ☐	Large print: ☐		Braille ☐	Other. ***Please state***: ☐		
	Is your child currently?	Homeless ☐		A Refugee ☐	An Asylum Seeker ☐		
	Is your child housebound?	Yes ☐ No ☐		Comments:			

4	**Medical background**				
	Are there any serious diseases that affect your child's **parents, brothers or sisters**? Tick all that apply ***and*** state **family member**:				
	Diabetes ☐ Who:	**Asthma** ☐ Who:	**Thyroid disorder** ☐ Who:	**Stroke** ☐ Who:	**COPD** ☐ Who:
	Heart Attack under age of 60 ☐ Who:	**Cancer (Specify type)** ☐ Who:	**High Blood pressure** ☐ Who:	**Any other important family illness. *Please state*:** Who:	
	Please state any allergies and sensitivities that your child has to medicines, food & dressings:				
	Please state any mental disabilities your child has:				
	Does your child have any problems taking medicines?	Yes ☐ No ☐	***If yes*** please give details, e.g. swallowing		

	What chronic medical conditions has your child had?	Date of Diagnosis:
	What operations has your child had?	Date of operation/s:
	What injuries has your child had?	Date of injury/s
	Please list any tablets, medicines or other treatments your child is currently taking / undertaking:	

5	Which vaccinations has your child had?				
Age	**Immunisation**	**Date (DD/MM/YY)**	**GP Surgery**	**Private**	**Abroad**
2 months	1st Diphtheria, Tetanus, Pertussis		☐	☐	☐
	1st Polio		☐	☐	☐
	1st HIB		☐	☐	☐
	1st Pneumococcal Vaccine		☐	☐	☐
	1st Rotavirus		☐	☐	☐
3 months	2nd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	2nd Polio		☐	☐	☐
	2nd HIB		☐	☐	☐
	1st Meningitis C		☐	☐	☐
	2nd Rotavirus		☐	☐	☐
4 months	3rd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	3rd Polio		☐	☐	☐
	3rd HIB		☐	☐	☐
	2nd Pneumococcal Vaccine		☐	☐	☐
	2nd Meningitis C		☐	☐	☐
12 months	Hib/Men C Booster		☐	☐	☐
13 months	MMR (Measles, Mumps, Rubella)		☐	☐	☐
	3rd Pneumococcal Vaccine		☐	☐	☐
3½ to 5 years	MMR Booster (Measles, Mumps, Rubella)		☐	☐	☐
	Pre- School Booster Diphtheria, Tetanus, Pertussis & Polio		☐	☐	☐

6	**Sharing your child's medical record**
	Medical Record Sharing allows your child's complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your child's shared medical record. **If you don't want to share your child's GP record tick here:** ☐
	Summary Care Records containsdetails of your child's key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your child's Summary Care Record. **If you don't want your child to have a Summary Care Record tick here:** ☐
	The Care.data Programme Collates information about your child and the care they receive. It links information from all the different places where your child receives care, such as their GP, hospital and community services, to help them provide a full picture of your child's medical needs and the care they are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes. **I wish to OPT OUT from my child's Personal Confidential Data being shared outside their *GP practice*:** ☐ **I wish to OPT OUT from my child's Personal Confidential Data being shared with *third parties*:** ☐

7	**Required Information**	
	Name of parent/s:	1. 2.
	Name of person with legal parental responsibility:	
	Name of school attended:	

8	**Parent / Guardian permission given** Permission given for someone other than a Parent/Guardian to accompany your child to an appointment?	
	Name of person/s: Relationship:	Parent / Guardian Signature:

9	**Signature**	
	Parent/Guardian signature:	Date:

Thank you for completing this form

For more information about the services we offer, please refer to our practice leaflet

Or see our website