# Picture1

**Child New Patient Registration**

**Please be aware, if your child is 16 years or older they are considered an adult and would need to complete an Adult Registration Form.**

Thank you for choosing to register with us. In this pack you’ll find information about the practice and how to register. Please take the time to complete the enclosed forms as fully as possible as this will enable us to provide you with the best possible care while we wait for your medical record to arrive from your previous practice (if applicable).

If your child is on regular medication you will need to book an appointment with the doctor at least two weeks before their current supply runs out. Please bring their prescription or medication with them to this appointment.

For your convenience we offer an email service whereby you can make appointments for your child with a doctor or order repeat prescriptions. To request medication or an appointment please email cuckfield.reception@nhs.net

We are a two site practice. Whilst we will make every effort to offer your child an appointment at the site of your choice this may not always be possible, especially if your child requires an urgent same day appointment when they may need to attend at either Cuckfield or the Vale Surgery.

**Guidelines for Registering with Cuckfield Medical Practice & The Vale Surgery**

In accordance with guidelines laid down by the PCSS Counter Fraud and Probity Department we are now required to get identification from any patient wishing to register with the practice.

**Forms of identification which are acceptable:**

Please note that **ONE** item from the 3 listed below will be required when registering your child.

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| **List A**  |
| [ ]  Birth Certificate [ ]  Passport [ ]  Immunisation Book |

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| **FOR OFFICE USE ONLY – Please tick when completed:** |
| 🞎 GMS Form | 🞎 ID Photocopied | 🞎 Allocated GP | **Staff Initials:** |



**New Child Patient Registration Form / Health Questionnaire**

|  |  |
| --- | --- |
| Please complete all parts of this form for your child and take to Reception at either surgery along with the ID as detailed in this document. Please complete this form electronically, print out and bring in to one of the surgeries. | **Date form Completed** |
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|  |  |  |
| --- | --- | --- |
| **Child Title** | **Child Surname** | **Child First Name** |
|  |  |  |

|  |
| --- |
| **Child Current Address** |
|  |
| **Child Postcode:** |  | **Child Date of Birth:** |  |

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| **Ethnicity** |

Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes.

**I would describe my child’s ethnic origin as:** (Please tick as appropriate)

|  |  |  |
| --- | --- | --- |
| **Asian or Asian British** | **Black or Black British** | **Mixed** |
| [ ]  Bangladeshi[ ]  Indian [ ]  Pakistan[ ]  Any other Asian background | [ ]  African[ ]  Caribbean[ ]  Any other Black background | [ ]  White and Asian[ ]  White and Black African[ ]  White and Black Caribbean[ ]  Any other mixed background |
| **Other Ethnic Group** | **White** | **Non-disclosure** |
| [ ]  Chinese[ ]  Any other ethnic group | [ ]  British[ ]  Irish[ ]  Any other White background | [ ]  I do not wish to disclose my ethnic origin |

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| **Language(s) Spoken**  |
|  |
| **Contact Details** |

|  |  |
| --- | --- |
| **Parent Mobile Phone Number**  | **Parent Home Phone Number** |
|  |  |

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| --- |
| **Parent Email address** |
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| **Preferred Pharmacy** |

The Pharmacies listed below collect regularly from the Practice. If you would like to make use of this service please indicate by ticking one of the boxes **OR** your prescription can also be collected from the Practice so you can take it to any Pharmacy of your choice.

|  |  |
| --- | --- |
| **Collection** | **Pharmacies** |
| [ ]  Collect From Cuckfield[ ]  Collect from The Vale | [ ]  Lloyds in Cuckfield [ ]  Lloyds in Haywards Heath [ ]  Kamsons in Haywards Heath [ ]  Boots Chemist NEP[ ]  Northlands Wood Pharmacy[ ]  Boots Chemist in Haywards Heath |

|  |
| --- |
| **Next of Kin** |

|  |  |  |
| --- | --- | --- |
| **Title** | **Surname** | **First Name** |
|  |  |  |

|  |
| --- |
| **Current Address if different from your child** |
|  |
| **Postcode:** |  | [ ]  Address same as above |

|  |  |  |
| --- | --- | --- |
| **Relationship to your Child** | **Next of Kin Home telephone** | **Next of Kin Mobile phone** |
|  |  |  |

|  |
| --- |
| **Do you live with anyone else registered here as a Patient? If so, whom (please give full names):**  |
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| **Consent to Leaving Messages and Communicating with you** |

In accordance with the Data Protection Act, the Practice requires written consent from any patient who is happy for us to leave a message on their answer phone in the event that we need to contact them. If we do not have written consent, and are unable to leave a message it may be difficult to contact you if we need to do so quickly.

**Please tick all the boxes that apply, this consent will commence from the date of registration:**

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| **I give consent for the Practice to leave voicemail messages about my child on my:** |
| [ ]  Home Phone | [ ]  Mobile Phone |

|  |
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| **I give consent for the Practice to leave a message about any aspect of my child’s medical treatment:** |
| With:  | Relationship to you:  |

|  |
| --- |
| **I give consent to receiving the following from the Practice:** |
| [ ]  SMS (text) appointment confirmation and reminders | [ ]  Emails |

Please be aware that the integrity and security of emails cannot be guaranteed on the internet and whilst every effort is made to keep this information secure, you should be aware that we cannot offer any guarantees of absolute privacy.

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| **Past Medical History** |

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| **Does your child suffer with a chronic condition i.e. heart disease, lung disease, high blood pressure, diabetes? OR has your child had a serious illness or operation?** |
| [ ]  Yes | [ ]  No |

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| **If yes, please give details** |
|  |

**Medication**

|  |
| --- |
| **Does your child take regular Medication? (If yes, please give details below)** |
| [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dosage** | **How often** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Immunisations** |

Please give details below of your child’s vaccination history:

|  |  |
| --- | --- |
| **Vaccinations** | **Date Given** |
| Tetanus/Diptheria/Polio |  |
| Meningitis C |  |
| BCG |  |
| Hepatitis A | Dose 1:  | Dose 2:  |
| Typhoid |  |
| Hepatitis B | Dose 1:  | Dose 2:  | Dose 3:  | Blood Test Result:  |
| Yellow Fever |  |
| Pneumovax |  |
| MMR |  |

**If you have your child’s red immunisation book please bring it with you and we will take a copy of their immunisation record.**

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| **Allergies** |

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| **Does your child have any Allergies or Sensitivities?** |
| [ ]  Yes | [ ]  No |

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| **If yes, please give details** |
|  |