Children's Health Form

>5 YRS CHILD NPC BOOKED □

Today's Date: _____

Name: _____

Date of Birth: _____

Male/Female: _____

Address: _____

_____

Town and Country of Birth: _____

School attended: _____

Is this a special needs school? YES/NO

Family History

Please provide us with information on the health of your family?

Parents:

	Age	State of Health
Mother		
Father		

Brothers or Sisters:

Boy/Girl	Age	State of Health

Are there any family illnesses?
(e.g. heart problems, diabetes)

Medication

Does your child take any routine medication?
(e.g. Inhalers)

Please enclose last prescription re-order form

If yes, please give us details as follows:

Drug Name	Dose	How Many Times a Day

Is your child allergic to any medication that you know of?
(e.g. penicillin)

If yes, what?

Carer

Are you a young carer? If YES who do you care for?

THIS INFORMATION IS ESSENTIAL FOR REGISTRATION

Immunisations Given and Date

DTaP/IPV/Hib (1) _____
DTaP/IPV/Hib (2) _____
DTaP/IPV/Hib (3) _____

Pneumococcal (1) _____
Pneumococcal (2) _____
Pneumococcal (3) _____
MMR 1st _____
MMR Booster _____

Hib/MenC _____
Men C (1) _____
Men C (2) _____
DT Booster _____
Polio Booster _____

FOR FEMALES UNDER 18 YEARS OLD PLEASE GIVE DATE GIVEN FOR:
Human Pappillomavirus (HPV) _____

Medical History

Has your child ever suffered from the following?

If YES. Please tick appropriate item and add the year alongside the condition.

	Year
*** Epilepsy**	
*** Diabetes**	
*** Cancer**	
*** Asthma**	
*** Hayfever**	
*** Jaundice**	
*** Skin Disease**	

Operations:
(Specify and give approx. year e.g.)

Has your child attended A&E if YES state:
When? Why?

Has your child had any other significant illnesses?

Disabilities

Please indicate if your child has any of the following conditions.
If YES. Please tick appropriate item.

□ **Impaired Hearing/Deaf** _____
□ **Speech Impaired** _____
□ **Partially Sighted/Blind** _____
□ **Mobility Impaired** _____
□ **Learning Disabilities** _____

Please bring the completed form with you when you register at this practice.