**Please complete ALL sections on this form in BLOCK CAPITALS and return with the purple GMS1 form, plus baby book or birth certificate as proof of identity**

**Please bring a copy of your child's vaccination book so that we can update the medical record.**

|  |  |  |  |
| --- | --- | --- | --- |
| **TITLE**  | Master / Miss |  |  |
| **DATE OF BIRTH** |  | **ARE YOU:** | **MALE / FEMALE** |
| **SURNAME** |  | **FORENAME** |  |
| **ANY PREVIOUS SURNAME(S)** |  | **MIDDLE NAME(S)** |  |
| **ADDRESS AND POSTCODE** |  | **HOME TELEPHONE** **MOBILE NUMBER** |
| **PLACE OF BIRTH** |  |
|  |  |  |
| **ETHNICITY - Please CIRCLE your answer** |
| White British | British / Mixed | White & Asian | Other White | Other Mixed |
| White & Black African | Other Black | Indian / British Indian | British / British Pakistani | British / British Bangladeshi |
| Chinese | Other Asian |  |  |  |
| **Other – PLEASE STATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **MAIN LANGUAGE SPOKEN** | Do you require an interpreter? **YES / NO**If YES, is there a specific dialect needed? |
|  |  |  |
| Do you give consent for us to send you text messages or emails from the surgery?  | **TEXT**  **YES / NO****EMAIL YES / NO** |
| Do you give consent for us to share your Summary Care Record with hospitals in an emergency situation? | **YES / NO** |
| **NEXT OF KIN DETAILS** Please provide details of your next of kin.  |
| **NAME** |  | **MALE / FEMALE** |
| **CONTACT NUMBER** |  | **RELATIONSHIP TO PATIENT** |
| **DO YOU GIVE US PERMISSION TO DISCUSS YOUR CARE WITH THIS PERSON IN AN EMERGENCY?** | **YES / NO** |
| **EMERGENCY CONTACT** Please give details of the person we should contact on your behalf in case of an emergency (if this person is not your next of kin) |
| **NAME** |  | **MALE / FEMALE** |
| **CONTACT NUMBER** |  | **RELATIONSHIP TO PATIENT** |
| **DO YOU GIVE US PERMISSION TO DISCUSS YOUR CARE WITH THIS PERSON IN AN EMERGENCY?** | **YES / NO** |
|  |  |
| **IS YOUR CHILD ALLERGIC TO ANYTHING?** | **YES / NO** | If yes, please provide details  |
|  |
| Your child will automatically be registered for our Online Services, to enable you to order repeat medications.The prescriptions will be sent electronically to a pharmacy of your choice. Please let us know which Pharmacy you wish to use **here –** **MY NOMINATED PHARMACY IS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **IF ANY OF THIS INFORMATION CHANGES IN THE FUTURE PLEASE NOTIFY THE SURGERY, IN WRITING OR BY EMAIL, AS SOON AS POSSIBLE.** |