Garden City Surgery CHILD

57-59 Station Road
Letchworth Garden City
SG6 3BJ

REGISTRATION FORM

PLEASE COMPLETE IN BLACK INK & IN CAPITALS

Surname: ..... First Names: .....

Home Tel: *(Landline only)*..... Work Tel: .....

Mobile Tel: ..... Email: .....

Preferred contact method: Letter/Email/SMS (*circle as required*)

Does your child have any information or communication needs? Yes/No

How can we meet your needs ?.....

Consent to use mobile number for text alerts: ☐ ***(please tick if you consent)*** **(XaQid)**

First Language:

Akan		Gujarati		Punjabi	
Albanian		Hakka		Russian	
Amharic		Hausa		Serbian/Croatian	
Arabic		Hebrew		Sinhala	
Bengali & Sylheti		Hindi		Somali	
Brawa & Somali		Igbo (Ibo)		Spanish	
British Signing Language		Italian		Swahili	
Cantonese		Japanese		Swedish	
Cantonese & Vietnamese		Korean		Sylheti	
Creole		Kurdish		Tagalog (Filipino)	
Dutch		Lingala		Tamil	
English		Luganda		Thai	
Ethiopian		Makaton		Tigrinya	
Farsi (Persian)		Malayalam		Turkish	
Finnish		Mandarin		Urdu	
Flemish		Norwegian		Vietnamese	
French		Pashto		Welsh	
Gaelic		Patois		Yoruba	
German		Polish		Other (*please state*)	
Greek		Portuguese			

Ethnic Origin: (please tick)

White British		Irish	
British/Mixed British		White & Black Caribbean	
Other White		Caribbean	
White & Black African		Other Black	
African		Indian/British	
White & Asian		Bangladeshi/British	
Pakistani/British		Other Mixed	
Other Asian		Other	
Chinese		Would prefer not to say	

Are you a carer? Do you look after someone who relies on you for support? Yes / No

Who do you care for? .....

Do you have a carer? Yes / No Carer's name:.....

Carer's Address:

.....

Contact No: .....

Child's Next of Kin & their relationship to your child

Name.....

Relationship to your child**.....**

Their Address:

.....

Contact No:.....

Childcare contact details (Nursery/Childminder/ Relative)

Name.....
Address.....
Telephone number.....

Medical History:

Does your child have any **current medical problems**? Yes / No

Details:

.....

.....

.....

Is your child taking any **medication**? Yes / No

If yes, please provide a copy of your repeat list.

Does your child have any **allergies**? Yes / No

Details:

.....

.....

.....

Signed: .....

Thank you for completing this questionnaire

OFFICE USE:

	DATA ENTERED
Consent to text - XaQid	
NOK information	
Ethnicity	
First language	
Information or communication needs	
Is a Carer	
Has a Carer	
Allocated GP	
Named GP	
Consent to organ donor	
Blood donor (min. age of 17)	
SCR informed dissent	
Preferred method of communication	
Registration Completed by & date	
Registration Checked by & date	