**Please bring the child’s Red Book with you so we can take a copy of their immunisation record.**

|  |
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| **CONFIDENTIAL MEDICAL REGISTRATION FORM (Children Under 16)** |
|  |
| **Child’s Personal Details:** |
|  |

**Please complete all pages in FULL using BLOCK capitals**

|  |  |
| --- | --- |
| Child’s Surname: |  |
|  |  |
| Child’s First Names (in full): |  |
|  |  |
| Previous Surnames: |  |
|  |  |
| **Title:** | ❒ Master ❒ Miss ❒ Ms ❒ Male ❒ Female |
|  |  |
| Date of Birth (day/month/year): |  |  |  |  |  |  | NHS Number:(if known) |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Town & Country of Birth: |  |
|  |  |
| Address: | Post Code:  |
|  |  |
| Telephone Number: |  | Mobile Number1: |  |
|  | 1  Note, we use the mobile number for text messages.Text messages will automatically cease when the Child is 11 years old. |
|  |  |  |  |
| Email Address2: |  |
|  |  |
| 2  Please specify whose above email address this is, e.g. parent, guardian etc. |  |
|  |  |
| **Name of Parent(s) / Carers** | **Has Legal / Parental Responsibility?** | **Next of Kin?** |
| 1.
 |  ❒ Yes ❒ No |  ❒ Yes ❒ No |
| 1.
 |  ❒ Yes ❒ No |  ❒ Yes ❒ No |
|  |  |
| **Is the child a child in care?** ❒ Yes ❒ No**Is the child a “Looked After Child”?** ❒ Yes ❒ No**If yes to either of the above questions, in what capacity?** ❒ Temporary ❒ Permanent Name of Social Worker: …………………………………………………………………………………………Social Worker’s Phone No: ………………..……………………………………………………………………….Name of child’s nursery/school ……………..………………………………………………………………………. |
|  |

Is your child looking after someone at home? ❒ Yes ❒ No

|  |  |
| --- | --- |
| If so, who3? |  |

3  Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

|  |  |
| --- | --- |
| What is the adult’s relationship to the child? |  |

Do you think the child would like additional support as a young carer? ❒ Yes ❒ No

Is the child known to services such as Young Carers? ❒ Yes ❒ No

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| **Please help us trace the child’s previous medical records by providing the following information:** |
|  |
| Your previous address in the UK: | Post Code:  |
|  |  |
| Name of previous Doctor while at that address: |  |
|  |  |
| Surgery Name and Address of previous Doctor: | Post Code:  |
|  |  |
| **If you are from abroad:** |
|  |
| Your first UK address where Registered with a GP: | Post Code:  |
|  |  |
| If previously resident in UK date of leaving: |  | Date you firstcame to the UK: |  |

|  |
| --- |
| **Family Medical History:** |
|  |

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Heart Disease** | **Stroke** | **Diabetes** | **High Blood Pressure** | **Asthma** | **Glaucoma** | **Cancer** | **Mental Health Problems** | **Renal/ Kidney** | **Learning Difficulties** |
| **At the time of diagnosis they were:** |
| **Over****60 yrs old** |  |  |  |  |  |  |  |  |  |  |
| **Under** **60 yrs old** |  |  |  |  |  |  |  |  |  |  |

|  |
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| **Child’s Immunisations:** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunsation** | **Date** | **Immunisation** | **Date** |
| Tetanus |  | Booster: Tetanus |  |
| Whooping Cough |  | Booster: Diphtheria |  |
| Polio |  | Booster: Polio |  |
| HiB |  | Booster: MMR |  |
| Measles |  |  |  |
| MMR |  |  |  |
| BCG (TB) |  |  |  |
| Meningitis |  |  |  |

Please provide details of your child’s immunisations with dates if possible (under 5’s). If possible please give your Red Book to Reception to photocopy:

|  |
| --- |
| **Child’s List of Current Medication:** |
|  |
| **Name of Medication**  | **Dosage** |
|  |  |
|  |  |
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| --- |
| **Child’s Ethnicity:** |
|  |

❒ British or mixed British ❒ Irish ❒ African ❒ Caribbean ❒ Indian ❒ Pakistani

❒ Bangladeshi ❒ Chinese ❒ Other (please state):

❒ Decline to state

|  |
| --- |
| **Child’s Language:** |
|  |
| Please state child’s main spoken language: |  |

Does the child need an interpreter? ❒ Yes ❒ No

|  |
| --- |
| **Consent** |
|  |

Where you have provided information on how to contact you, can you confirm you are happy for the practice to contact you by the following:

By email ❒ Yes ❒ No This will be to send you letters, the practice newsletter and the like

By text ❒ Yes ❒ No This will be to send you reminders of appointments via text

|  |
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| **Signatures:** |
|  |

I confirm that the information that has been provided is true to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

Signature on behalf of patient ❒ Signature of patient ❒

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Person |  | Relationship to Child: |  |