**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)** |
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| **Child’s Personal Details:** | |
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**Please complete all pages in FULL using BLOCK capitals**

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| Child’s Surname: | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Child’s First Names (in full): | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Previous Surnames: | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Title:** | | ❒ Master ❒ Miss ❒ Ms ❒ Male ❒ Female | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Date of Birth (day/month/year): | |  |  |  | |  |  |  | | | NHS Number: (if known) |  |  |  |  |  |  |  | | |  | |  | |  | |
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| Town & Country of Birth: | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Address: | | Post Code: | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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. | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Email Address2: | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2  Please specify whose above email address this is, e.g. parent, guardian etc. | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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| **Name of Parent(s) / Carers** | | | | **Has Legal / Parental Responsibility?** | | | | | | | | **Next of Kin?** | | | | | | | | | | | | | | |
|  | | | | ❒ Yes ❒ No | | | | | | | | ❒ Yes ❒ No | | | | | | | | | | | | | | |
|  | | | | ❒ Yes ❒ No | | | | | | | | ❒ Yes ❒ No | | | | | | | | | | | | | | |
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| **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 ……………..………………………………………………………………………. | | | | | | | | | | | | | | | | | | | | | | | | | | |
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Is your child looking after someone at home? ❒ Yes ❒ No

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| 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

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| 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:** | | | |
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| 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 first came to the UK: |  |

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

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|  | **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:** |
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| **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:

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| **Child’s List of Current Medication:** |
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| **Name of Medication** | | **Dosage** |
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| **Child’s Ethnicity:** |
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❒ British or mixed British ❒ Irish ❒ African ❒ Caribbean ❒ Indian ❒ Pakistani

❒ Bangladeshi ❒ Chinese ❒ Other (please state):

❒ Decline to state

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

Does the child need an interpreter? ❒ Yes ❒ No

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

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

Signature on behalf of patient ❒ Signature of patient ❒

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