**Child Registration Form**

**CHILDREN AGED O-16 YEARS**

Please make sure that we have all the correct contact & health information about your child to register them. Please complete the following carefully and **PRINT CLEARLY**

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| **Date Registered** |
| **Title Mr/Miss** |
| **Child Forenames:** | **Child Date of birth****NHS Number:** |
| **Childs Surname:** | **Country of birth:****Nationality:****Gender:** |
| **Address :** | **Telephone:****Mobile:** |
| **Last UK Address:** | **Date of Arrival in UK (if applicable)** |
| **If previously resident in the UK, Please give date of departure:**  | **Name & Address of Previous GP:** |
| **Mother’s name: Telephone:** **Mobile:****(or name of adult with parental responsibility)**  |
| **Father’s name: Telephone:** **Mobile:****(or name of adult with parental responsibility)**  |
| **Does the child have an allocated social worker? Yes No** |
| **Name of School/Nursery if attending:** |
| **Name of social worker:** **(if Known)**  |
| **Is the child fostered privately? Yes No**  |
| **Has Childs ID been Supplied?** |  |
| **Birth Certificate** | **Yes/No** |
| **Passport** | **Yes/No** |
| **Red book (Photocopy)** | **Yes/No** |
| **Adoption Certificate** | **Yes/No** |
| **Looked after Child** | **Yes/No** |
| **No Documents/Other Documents** | **Yes/No** |

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| --- | --- | --- | --- |
| **School/Child Care Details**  | **Nursery** | **Child Minder**  | **School** |
| **Name:** |  |  |  |
| **Address:** |  |  |  |
| **Telephone:** |  |  |  |

***Siblings Details***

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** | **First Name** | **Date of Birth** | **Gender** |
|   |   |   |   |
|   |   |   |   |
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| --- | --- | --- | --- |
| **Surname*****People living in the same Household in addition to above***  | **First Name** | **Date of Birth** | **Relationship to child**  |
|   |   |   |   |
|   |   |   |   |
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The Practice now collects information about patients’ ethnicity. This helps us to learn more about health needs of our community all information we receive will be used in the strictest confidence.

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| ***Ethnic origin***  |
| **Asian or Asian British** | **Bangladeshi** | **Indian** | **Pakistani** | **Other Asian background:** |
| **Black or Black British** | **African** | **Caribbean** | **Other black background:** |
| **Chinese or other ethnic group** | **Chinese** | **Other ethnic group:** |
| **Mixed background** | **White & Asian** | **White &Black Caribbean** | **Other mixed background:** |
| **White** | **British** | **Irish** | **Other white background:** |
| **What Is your Religion?** |
| **Main spoken language****Language read** |
| **Do you require an interpreter? Yes No** |

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| **MEDICAL HISTORY** |
| Is your child on any medication at present? |  |
| Is your child allergic to anything? |  |
| Has your child had any operation or serious illness? |  |

***Childs Immunisations***

If your child is 0-5 Yrs please kindly provide us with the information about your child immunisations that they have received. If you are unsure which vaccinations you child has had it would be helpful if you can bring along any records you have in your RED Child Health Book when you next come to the Practice.

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| **Age Due** | **Vaccine** | **Tick if Given** | **Date Given** | **At GP Sugery** | **Other** |
| **Birth Onward** | **BCG****Hepatitis B course of 4 injection at birth1,2 and 6mths** |  |  |  |  |
| **2 months**  | **1st DTP & Hip & Polio****1st Pneumococcal +Meningitis B** |  |  |  |  |
| **3months**  | **2nd DTP & Hip & Polio****Meningitis C** |  |  |  |  |
| **4months**  | **3rd DTP & HIP & Polio****2nd Meningitis C & 2nd Pneumococcal +Meningitis B** |  |  |  |  |
| **12-13 months** | **1st MMR (or 3 mths after 1st MMR)****HIB/Men C ,Pneumococcal + Meningitis B** |  |  |  |  |
| **3yrs 4 Months** | **Dip/Tet/Pertussis +Polio Booster****2nd MMR** |  |  |  |  |
| **Are there any vaccinations you don’t want your child to have?** Yes NoIf you would like to discuss any of the vaccinations please ask the reception team to help you ask the Nursing Team or see the immunisation Website at [www.nhs.uk](http://www.nhs.uk)  |
| **Summary Care Records** : These are electronic records of your childs medications \* allergies that can be accessed (with your consent Only) in the event of an Emergency ( for example at an A&E Department) If you wish to opt out of having the SCR, please ask or complete form which you will find on the website. |
| **PLEASE SUPPLY VACCINATION DETAILS INCLUDING DATES OF VACCINES IF GIVEN ABROAD** |

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| **The information you have provided will be kept in the strictest confidence Under the Data Protection Act** |

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| --- | --- |
| **Parent or Guardian Signature:** | **Date:** |
| **Print Name:**  |  |
| **Date or Birth:** |  |
| **Address:**  |  |
| **RELATIONSHIP TO CHILD:** |  |

**If you are a Support Worker or Carer or Advocate for a patient at this Practice please could you provide us with the following information so that we can work together to safeguard them:**

**Patient has consented to me completing this form YES / NO**

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your title and full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The agency you work for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your work contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date when you started working with this patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your days and hours of work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your title and full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Your days and hours of work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Initial

**STAFF USE ONLY**: Date:

Birth cert & Id Verified Yes No

Summarise Urgently Yes No

Adult Registering Child has Parental Responsibility? Yes No

Appointment offered if immunisation not up to date Yes No