

New Patient Registration Form (Children: under 16s)

Instructions for completing this form on behalf of a Child

Date:

1. Complete a separate form for each child to be registered

1	Full Name:		Telephone Number:		
	Title : Master		Miss		
	Other. <i>Please state :</i>				
	NHS number if known:		We will use this to send appointment reminders and health promotion details. Please tick here if you do not wish to receive messages from us:		
	Address:		E-mail address:		
	Postcode:		Next of Kin:		
	How would like us to contact you about your child:		Next of Kin Relationship to child:		
	Letter Email		Next of Kin contact tel. number:		
	SMS (text) Phone				
	Date of Birth:	Gender: Male Female		Mothers name if different:	
Town* and Country of birth (*If town is London please state which Borough)		Country: Town:		Borough (*If born in London):	
Please list other residents of your home who are registered with us:		Name:		Date of Birth:	

2. Complete in BLOCK CAPITALS and tick the boxes and fill in each section as appropriate

2 Looking after a family member		
Is your child looking after someone? Let us know if your child is looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems	Yes	No
Is someone looking after your child? Let us know if a family member, friend or neighbour looks after your child.	Yes	No
Carer's name:		

Address of carer :

Telephone number of carer:

3	Your Child's Religion (Please tick)	C of E	Catholic	Other Christian (state):	Buddhist	Hindu	Muslim	
		Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)		
	Your Child's Ethnic Origin (Please tick one)	White (UK)		White (Irish)	White (Other)			
	Black Caribbean / British	Indian / British Indian		Arabic	Other Mixed Background			
	Black African / British	Pakistani / British Pakistani		Chinese	Other Asian Background			
	Other Black Background	Bangladeshi / British Bangladeshi		Other	Ethnic Category Refused			
	What is your child's main spoken language?				Does your child need an Interpreter?			
	Does your child speak English? Yes No				Yes No			
	Does your child need help with mobility/hearing/speaking? (tick all that apply)							
	Wheelchair	Walking aid		Hearing aid	British sign language (BSL)	Makaton sign language		
Lip reading:	Large print:		Braille	Other. <u>Please state:</u>				
Is your child currently?	Homeless		A Refugee	An Asylum Seeker				
Is your child housebound?	Yes No		Comments:					

Please state all countries your child has lived in or visited for periods of greater than 6 months:

Country:

Dates/Year (If known):

4	Medical background			
<p>Are there any serious diseases that affect your child's parents, brothers or sisters? Tick all that apply <i>and</i> state family member:</p>				
Diabetes	Asthma	Thyroid disorder	Stroke	COPD
Who:	Who:	Who:	Who:	Who:
Heart Attack under age of 60	Cancer (Specify type)	High Blood pressure	Any other important family illness. <i>Please state:</i>	
Who:	Who:	Who:	Who:	
Please state any allergies and sensitivities that your child has to medicines, food & dressings:				
Please state any mental disabilities your child has:				
Does your child have any problems taking medicines?		Yes No	<i>If yes</i> please give details, e.g. swallowing	
What chronic medical conditions has your child had?				Date of Diagnosis:
What operations has your child had?				Date of operation/s:
What injuries has your child had?				Date of injury/s
Please list any tablets, medicines or other treatments your child is currently taking / undertaking:				

5 Which vaccinations has your child had?					
Age	Immunisation	Date (DD/MM/YY)	GP Surgery	Private	Abroad
2 months	1st Diphtheria, Tetanus, Pertussis				
	1st Polio				
	1st HIB				
	1st Pneumococcal Vaccine				
	1st Rotavirus				
	1st Meningitis B				
3 months	2nd Diphtheria, Tetanus, Pertussis				
	2nd Polio				
	2nd HIB				
	1st Meningitis C				
	2nd Rotavirus				
4 months	3rd Diphtheria, Tetanus, Pertussis				
	3rd Polio				
	3rd HIB				
	2nd Pneumococcal Vaccine				
	2nd Meningitis B				
12 months	Hib/Men C Booster				
	3rd Meningitis B				
13 months	MMR (Measles, Mumps, Rubella)				
	3rd Pneumococcal Vaccine				
3½ to 5 Years	MMR Booster (Measles, Mumps, Rubella)				
	Pre-School Booster Diphtheria, Tetanus, Pertussis & Polio				
13-18 Years	Booster Diphtheria, Tetanus & Polio				
	1st Meningitis A				
	Meningitis C				
	1st Meningitis W				
	1st Meningitis Y				

6 Sharing your child's medical record

Electronic Medical Record Sharing allows your child's complete GP medical record to be made available to authorised healthcare professionals involved in their care. You will always be asked your permission before anybody looks at your child's shared medical record outside of the GP practice.

IF YOU DO WANT OTHER HEALTHCARE PROFESSIONALS TO BE ABLE TO ACCESS YOUR CHILD'S GP RECORD ELECTRONICALLY

tick here: (we can only share these records WITH your consent)

Summary Care Records contains details of your child's key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your child's Summary Care Record.

IF YOU DO WANT AUTHORISED HEALTHCARE STAFF IN A&E DEPARTMENTS THROUGHOUT ENGLAND TO HAVE ACCESS TO YOUR CHILD'S SUMMARY CARE RECORDS

tick here: (we can only share these records WITH your consent)

The Care.data Programme Collates information about your child and the care they receive. It links information from all the different places where your child receives care, such as their GP, hospital and community services, to help them provide a full picture of your child's medical needs and the care they are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.

I wish to ALLOW my child's Personal Confidential Data to be shared outside their GP practice:

I wish to ALLOW my child's Personal Confidential Data to be shared with *third parties*:

7	ESSENTIAL Information	
	Name of parent/s:	1. 2.
	Name of person with legal parental responsibility:	
	Name of school attended:	

8	Parent / Guardian permission given	
	Permission given for someone other than a Parent/Guardian to accompany your child to an appointment?	
	Name of person/s: Relationship:	Parent / Guardian Signature:

9	Signature	
	Parent/Guardian signature:	Date: