

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

<b>1</b>	<b>Full Name:</b>		<b>Telephone Number:</b>	
	<b>Title :</b> Master <input type="checkbox"/>		Miss <input type="checkbox"/>	
	<b>Other. <i>Please state</i> :</b>		<b>Mobile tel. number:</b>	
	<b>NHS number if known:</b>			
	<b>Address:</b>		<b>E-mail address:</b>	
	<b>Postcode:</b>		<b>Next of Kin:</b>	
	<b>How would like us to contact you about your child, Please indicate 1<sup>st</sup> Choice:</b>		<b>Next of Kin Relationship to child:</b>	
	Letter <input type="checkbox"/> Email <input type="checkbox"/>		<b>Next of Kin contact tel. number:</b>	
	SMS (text) <input type="checkbox"/> Phone <input type="checkbox"/>			
	<b>Date of Birth:</b>	<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>		<b>Mothers name if different:</b>
<b>Town* and Country of birth</b>		<b>Country:</b>		<b>Borough (*If born in London):</b>
(*If town is London please state which Borough)		<b>Town:</b>		
<b>Please list other relatives of your home who are registered with us:</b>				
<b>Relationship:</b>		<b>Name:</b>		<b>Date of Birth:</b>

<b>2</b>	<b>Looking after Someone</b>		
	<b>Is your child looking after someone?</b> 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 <input type="checkbox"/> No <input type="checkbox"/>
	<b>Is someone looking after your child?</b> Let us know if a family member, friend or neighbour looks after your child.		Yes <input type="checkbox"/> No <input type="checkbox"/>
	<b>Carer's name:</b>		
	<b>Address of carer :</b>		
	<b>Telephone number of carer:</b>		

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

<b>Please state all countries your child has lived in or visited for periods of greater than 6 months:</b>	
<b>Country:</b>	<b>Dates/Year (If known):</b>

<b>4 Medical background</b>				
Are there any serious diseases that affect your child's <b>parents, brothers or sisters</b> ? Tick all that apply <b><i>and</i></b> state <b>family member</b> :				
Diabetes <input type="checkbox"/>	Asthma <input type="checkbox"/>	Thyroid disorder <input type="checkbox"/>	Stroke <input type="checkbox"/>	COPD <input type="checkbox"/>
Who:	Who:	Who:	Who:	Who:
Heart Attack under age of 60 <input type="checkbox"/>	Cancer (Specify type) <input type="checkbox"/>	High Blood pressure <input type="checkbox"/>	Any other important family illness. <b><i>Please state:</i></b> 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 <input type="checkbox"/> No <input type="checkbox"/>	<b><i>If yes</i></b> 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:	

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

<b>6</b>	<p><b>Sharing your child's medical record</b></p> <p><b>Medical Record Sharing</b> allows your child's complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your child's shared medical record.</p> <p><b>If you don't want to share your child's GP record tick here:</b> <input type="checkbox"/></p> <p><b>Summary Care Records</b> contains details of your child's key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&amp;E Departments throughout England. You will always be asked your permission before anybody looks at your child's Summary Care Record.</p> <p><b>If you don't want your child to have a Summary Care Record tick here:</b> <input type="checkbox"/></p> <p><b>The Care.data Programme</b> 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.</p> <p><b>I wish to OPT OUT from my child's Personal Confidential Data being shared outside their GP practice:</b> <input type="checkbox"/></p> <p><b>I wish to OPT OUT from my child's Personal Confidential Data being shared with <i>third parties</i>:</b> <input type="checkbox"/></p>
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<b>7</b>	<p><b>Required Information</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; border: 1px solid black;">Name of parent/s:</td> <td style="border: 1px solid black;">1.</td> </tr> <tr> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;">2.</td> </tr> <tr> <td style="border: 1px solid black;">Name of person with legal parental responsibility:</td> <td style="border: 1px solid black;"></td> </tr> <tr> <td style="border: 1px solid black;">Name of school attended:</td> <td style="border: 1px solid black;"></td> </tr> </table>	Name of parent/s:	1.		2.	Name of person with legal parental responsibility:		Name of school attended:	
Name of parent/s:	1.								
	2.								
Name of person with legal parental responsibility:									
Name of school attended:									

<b>8</b>	<p><b>Parent / Guardian permission given</b></p> <p>Permission given for someone other than a Parent/Guardian to accompany your child to an appointment?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: 1px solid black;">Name of person/s:</td> <td style="border: 1px solid black;">Parent / Guardian Signature:</td> </tr> <tr> <td style="border: 1px solid black;">Relationship:</td> <td style="border: 1px solid black;"></td> </tr> </table>	Name of person/s:	Parent / Guardian Signature:	Relationship:	
Name of person/s:	Parent / Guardian Signature:				
Relationship:					

<b>9</b>	<p><b>Signature</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; border: 1px solid black;">Parent/Guardian signature:</td> <td style="border: 1px solid black;">Date:</td> </tr> <tr> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> </tr> </table>	Parent/Guardian signature:	Date:		
Parent/Guardian signature:	Date:				

**Thank you for completing this form**  
***For more information about the services we offer, please refer to our practice leaflet***  
***Or see our website***