CHURCH ELM LANE MEDICAL PRACTICE

New Patient Registration Form (Children: under 16s)

Today's Date

Instructions for completing this form on behalf of a Child

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

1	**Full Name:**		**Mother's name:** **DOB:** **Contact number:** **Are you registered at the surgery: Y ☐ N ☐**
	Title : **Master ☐**	**Miss ☐**	**Father's Name:** **DOB:** **Contact number:** **Are you registered at the surgery: Y ☐ N ☐**
	Other. *Please state* **:**		**E-mail address:**
	NHS number if known:		**Date of Birth:**
	Address:		**Gender:** **Male ☐** **Female ☐**
	Postcode:		**Country of birth:** **Town:** **Borough:** **(*If town is London please state which Borough)**
	Name of person with legal parental responsibility : **(if different from mother/father)** **Contact tel. number:** **Address (if different from child):**		

2	**Carer's details**		
	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:	**Relationship to your child:**	
	Telephone number of carer:	**Is your child's carer registered with us?**	
	Address of carer:	**Does your carer speak** **English:** Yes ☐ No ☐	

3	**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 ☐	Please State: ……

What is your child's main spoken language?	
Do you (parent/guardian) speak English? Yes ☐ No ☐ If No, what is your main spoken language:	
Does you/child need an Interpreter?	Yes ☐ No ☐ If Yes, which language: .....

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. ***Please state***: ☐	

Is your child currently?	An Asylum Seeker ☐	A Refugee ☐	Homeless ☐	None ☐

Is your child housebound?	Yes ☐ No ☐	Comments:

4 Medical background

Are there any serious diseases that affect your child's **parents, brothers or sisters**?
Tick all that apply ***and*** state **family member**:

Diabetes ☐ Who:	**Asthma** ☐ Who:	**Thyroid disorder** ☐ Who:	**Stroke** ☐ Who:	**COPD** ☐ Who:
Heart Attack under age of 60 ☐ Who:	**Cancer (Specify type)** ☐ Who:	**High Blood pressure** ☐ Who:	**Any other important family illness. *Please state*:** 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 ☐	***If yes*** 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 Your Child Had? Child's Name:				
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		☐	☐	☐
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 C		☐	☐	☐
12 months	Hib/Men C Booster		☐	☐	☐
13 months	MMR (Measles, Mumps, Rubella)		☐	☐	☐
	3rd Pneumococcal Vaccine		☐	☐	☐
3 yrs 4 months to 5 years	MMR Booster (Measles, Mumps, Rubella)		☐	☐	☐
	Pre- School Booster Diphtheria, Tetanus, Pertussis & Polio		☐	☐	☐

6	**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:

7	**Signature**	
	Parent/Guardian signature:	Date:

Please Note

- **Please note to bring your child's red book or vaccination record for your new patient medical with Healthcare Assistant**
- **If child immunisation are done abroad, please bring in translated list for Nurse to add to your child's medical records**

Thank you for completing this form

For more information about the services we offer, please refer to our practice leaflet or see our website:

http://www.churchelmpractice.co.uk

OFFICE USE ONLY

DOCUMENT CHECKLIST(surgery use only)			
	Type of document (passport/bill etc)	Checked	Comments
BIRTH CERTIFICATE			
CHILD HEALTH BOOK			
ANY OTHER ID			

Documents checked by: …….. Date ……

Patient registered on system by: …… Date ……