CHILD REGISTRATION FORM (age 5 – 16 inclusive)

Please print clearly **Date** _____

Surname _____ **First Name/s**_____

Date of Birth _____ **Tel. Number** _____

Address _____

Postcode _____

Child's ethnic group (Please tick one)

British/Mixed British ☐ Irish ☐ Other White background ☐ White & Black Caribbean ☐

White & Black African ☐ White & Black Asian ☐ Other Mixed Background ☐

Indian/ British Indian ☐ Pakistani/British Pakistani ☐ Bangladeshi/British Bangladeshi ☐

Other Asian background ☐ Caribbean ☐ African ☐ Other Black Background ☐ Chinese ☐

Other ethnic group (please give details) ____ **Full name of Parents / Guardians**

Please confirm who has parental responsibility

Joint Mother only Father only Guardian

Tel. Number of Parent / Guardian (if different)_____

Name and address of current school _____

Have you ever been seen by a doctor or nurse at this surgery before? Yes / No

Child Vaccinations

WE REQUIRE COPIES OF ALL PREVIOUS VACCINATIONS FROM THE CHILD'S RED BOOK.

FOR ANY VACCINATIONS THAT HAVE BEEN GIVEN OVERSEAS WE REQUIRE DOCUMENTATION SHOWING DETAILS OF THESE VACCINATIONS AND THE DATES. AN APPOINTMENT IS TO BE BOOKED WITH THE NURSE TO DISCUSS THESE VACCINATIONS TO ENSURE VACCINATIONS ARE UPTO DATE.

Medical History

Do you suffer from: (please circle)

Asthma	Yes / No	Cancer	Yes / No
Diabetes	Yes / No	Epilepsy	Yes / No
Heart Disease	Yes / No	High Blood Pressure	Yes / No
Hypothyroidism	Yes / No	Mental Health Problems	Yes / No
Respiratory Diseases	Yes / No	Strokes	Yes / No

Have you ever had any other operations or illnesses (e.g. tonsils removed etc.) Yes / No

If Yes, (please list below and give dates where possible)

_____

_____

_____

_____

Family History

Has anyone in your immediate family suffered with: (please circle)

Asthma	Yes / No	Cancer	Yes / No
Diabetes	Yes / No	Heart Attack	Yes / No
High Blood Pressure	Yes / No	Stroke	Yes / No

Other _____

_____

General Health and Social History (please circle)

Height _____ Weight _____

Do you have any allergies? (e.g. aspirin, penicillin) No / Yes (give details) _____

_____

_____

Are you on any regular medication? No / Yes (give details)

1. _____ 2. _____
3. _____

4. _____ 5. _____
6. _____

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Office use only

Urine _____ Blood Pressure _____

Smoking Cessation Advice given Yes / No

Data Sharing: You hold the key and you can decide what information you share and who you share it with. We have attached an information sheet, opt out form and leaflet which will help you decide.