

EDEN PARK SURGERY

Please bring the child's Red Book with you so we can take a copy of their immunisation record.

CONFIDENTIAL MEDICAL REGISTRATION FORM (Children Under 16)

Child's Personal Details:

Please complete all pages in FULL using BLOCK capitals

Child's Surname:																				
Child's First Names (in full):																				
Previous Surnames:																				
Title:	Master	Miss	Ms	Male	Female															
Date of Birth (day/month/year):							NHS Number: (if known)													
Town & Country of Birth:																				
Address:																				
	Post Code:																			
Telephone Number:						Mobile Number ¹ :														
¹ Note, we use the mobile number for text messages. Text messages will automatically cease when the Child is 11 years old.																				
Email Address ² :																				
² Please specify whose above email address this is, e.g. parent, guardian etc.																				

Name of Parent(s) / Carers	Has Legal / Parental Responsibility?	Next of Kin?
1.	Yes No	Yes No
2.	Yes No	Yes No
If not the above, name of person with legal responsibility:		
Contact details of person with legal responsibility		

Does the child have any special communication / mobility needs? Yes No

If yes: Wheelchair Walking Aid Hearing Aid Large Print

 Lip Reading Braille British Sign Language

 Makaton Sign Language Other:

Is the child currently: A Refugee An Asylum Seeker

Is the child a child in care? Yes No

Is the child a “Looked After Child”? Yes No

If **yes** to either of the above questions, in what capacity? Temporary Permanent

Is the child home educated? Yes No

Name of Social Worker:

.....

Social Worker’s Phone No:

.....

Name of child’s nursery/school

.....

Has the child or family either currently or in the past been known to Children’s Services?

Yes No

Name of Social Worker:

.....

Social Worker’s Phone No:

.....

Required Information:

Is your child looking after someone at home? Yes No

If so, who³?

³ Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

What is the adult’s relationship to the child?

Do you think the child would like additional support as a young carer? Yes No

Is the child known to services such as Young Carers? Yes No

Is the child being privately fostered (*see definition below*)? Yes No

If **yes**, please provide carer’s name:

Carer’s relationship to child:

Contact details of carer:

Are Children’s services aware? Yes No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) ([S.66 Children Act 1989](#)) is placed for 28 days or more in the care of someone who is not the child’s parent(s) or a ‘connected person’. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, **but cannot be a relative** as defined under the [Children Act 1989, section 105](#): ‘A relative under the Children Act 1989 is defined as a ‘grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent’.

Please help us trace the child’s previous medical records by providing the following information:

Your previous address in the UK:

Post Code:

Name of previous Doctor while at that address:			
Surgery Name and Address of previous Doctor:			
	Post Code:		
If you are from abroad:			
Your first UK address where Registered with a GP:			
	Post Code:		
If previously resident in UK date of leaving:		Date you first came to the UK:	

If registering a child under 5:

I wish the child above to be registered with Organisation Name for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*:

For Dispensing Practices only:

I live more than 1 mile in a straight line from the nearest chemist

Patient Declaration for all patients who are not ordinarily resident in the UK:

Please see appendix 1 for patient declaration (last page of form)

Child's Personal Medical History:	
If under 5 years old, type of Birth: (eg normal, forceps, caesarean)	

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

Condition	Year Diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family Medical History:

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

	Heart Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal / Kidney	Learning Difficulties
At the time of diagnosis they were:										
Over 60 yrs old										
Under 60 yrs old										

Child's Immunisations:

Please provide details of your child's immunisations with dates if possible (under 5's). If possible

please give your Red Book to Reception to photocopy:

Immunisation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles			
MMR			
BCG (TB)			
Meningitis			

Child's List of Current Medication:	
Name of Medication	Dosage

Child's Allergies:

Please list any allergies the child has to any drugs/medications or if known egg allergy or peanut allergy:

Name of Medication	What was the problem or upset?

Child's Ethnicity:

British or mixed British Irish African Caribbean Indian Pakistani
 Bangladeshi Chinese Other (please state):
 Decline to state

Child's Religion:	
Please state religion of child:	

Please advise if you feel your child's religion will affect any treatment received: Yes No

Child's Language:	
Please state child's main spoken language:	

Does the child need an interpreter? Yes No

Data Sharing Consent Choices:

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for the practice to contact you by the following:

By email Yes No This will be to send you letters, the practice newsletter and the like

By text Yes No This will be to send you reminders of appointments via text

Signatures:

I confirm that the information that has been provided is true to the best of my knowledge.

Signed:

Date:

Signature on behalf of patient Signature of patient

Name of
Person

Relations
hip to
Child:

Box for extra details:

Updated 26/09/17
Appendix 1

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Patient's Details

Please complete in BLOCK CAPITALS and tick as appropriate

Mr Mrs Miss Ms

Surname:

Date of
Birth

First
Names:

NH
S
No.

Previous
Surname/s:

Male Female

Town and
Country of Birth:

Home Address:

Postcode:

Telephone No:

Scan and send this page of form to: NHSDigital-EHIC@nhs.net