ST MARY'S SURGERY

NEW PATIENT REGISTRATION FORM – CHILD up to 18 years old

Your child's contact details:

Surname:
First Name(s):
Gender: Male / Female
Previous Surname(s):
Home Tel:
Mobile Tel:
(Patients aged 11+)
MUST have their own mobile number)

Mother's Name:
Father's Name:
Date of Birth:
Home Address (including postcode):

Who has Parental Responsibility for this child?

Name: Address:	Relationship: Telephone Number:

Who else lives in this household? Mum ☐ Dad ☐ Step parent ☐ Parent's partner ☐ Grandparents ☐ Brothers and sisters ☐ Foster carer ☐ guardian ☐ Other ☐ please state

Does your child go to school, nursery or are they home schooled?

Does your child have a Special Needs Statement? (if yes, please give details) ☐ YES ☐ NO

Ethnic Group – Please tick which one you belong to

☐ British ☐ Chinese ☐ Asian or Asian British ☐ Indian or British Indian
☐ Black or Black British ☐ European ☐ Other Ethnic group – please specify

Does your child have any contact with any of the following?

Please can you tell us their names		YES	NO
A Hospital Specialist			
A Health Visitor			
A Social Worker			
Any other health professional			

Has your child ever been under a Child Protection Plan? ☐ YES ☐ NO

Does your child have a carer? (if yes, please give details) ☐ YES ☐ NO

Is your child a carer? (if yes, for whom) ☐ YES ☐ NO

Is your child registered disabled? (if yes, please give details) ☐ YES ☐ NO

Does your child have an communication needs e.g. large font / interpreter?

Were there any complications at birth? (if yes, please give details) □ YES □ NO

Medical Information

Please list any chronic conditions/serious illnesses/operations/accidents/disabilities your child has had and the year they took place

Has your child ever suffered from? (tick as appropriate)

	Yes	No		Yes	No
Epilepsy			Hayfever		
Diabetes			Asthma		
Cancer			Eczema		

Please list any medicines being taken and the amount:

This practice issues electronic prescriptions, therefore no paper ones are issued. Please nominate a pharmacy you would like your child's prescriptions to be sent to:

Is your child allergic to anything including medicines and if so, which? □ YES □ NO

Family History (please tick all which apply)

	Family Member	Age at Diagnosis
Heart Disease		
High Cholesterol		
Stroke/TIA		
Diabetes		

Please refer to our Practice Leaflet for further information

Signature: Date:

Of Parent/Guardian completing the form

For office use only:

Checked by _____Entered on computer by _____

EMIS No _____Date _____

(Please make sure the patient does not have an EMIS number already)