NHS

Child Registration Form

The White Horse Medical Practice

This information will remain strictly confidential.

Surname: _____ **First Name**: _____

Middle Name(s): _____

Address: _____

_____ Postcode: _____

DOB: _____/_____/_____ Town + Country of Birth: _____

Sex: **Female / Male** NHS Number: _____

Any complication at the birth of your child that the GP should be made aware of: _____

_____

_____

Parent(s) / Guardian Details

1) Full Name: _____ Relation to child: _____

Home Number:_____ Mobile: _____

Email Address: _____

Are you registered here at The White Horse Medical Practice yourself? **YES / NO**

2) Full Name: _____ Relation to child: _____

Home Number: _____ Mobile: _____

Email Address: _____

Are you registered here at The White Horse Medical Practice yourself? **YES / NO**

If you need your doctor to dispense medicines and appliances

☐ We live more than 1 mile in a straight mile from the nearest chemist

☐ We would have serious difficulty in getting them from a chemist

Ethnic origin & Language – please indicate which ethnic group your child belongs to and the main language that will be spoken. This is important information to help us understand better the health needs of our patients.

White	British Any other white background (please specify)	
Mixed	Any mixed background (please specify)	
Asian	Indian Pakistani Bangladeshi Chinese Any other Asian background (please specify)	
Black	Caribbean African Any other Black background (please specify)	
Other ethnic background	Any other background (please specify)	
Language Spoken	English	Other (please specify)

PLEASE ENSURE YOU COMPLETE PAGE 2, THANK YOU

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CHILD HEALTH QUESTIONNAIRE

Please help us trace your previous medical records by providing the following information

Your previous address in UK: **Post code**:	**Name of previous Doctor**: **Address of previous Doctor:**
If you are from abroad, your first UK address where registered with a GP:	**First date of entry to the UK**

CHILD'S MEDICAL HISTORY

Has your child had:

☐ **Measles** ☐ **German Measles** ☐ **Mumps**
☐ **Chicken Pox** ☐ **Whooping Cough** ☐ **Fits or seizures**
☐ **Asthma**

Any serious illnesses or accidents (please specify) ……..……..….

……..…….

Any Hospital admissions (when and reason) ……...

……

Any regular medication……

……..

Any allergies……..

……

Is there any history of fits or epilepsy in the child's biological parents or siblings? ……..

……

IMMUNISATIONS

Please provide documentation containing your child's vaccination history i.e. **Red book**. If you are unable to do so, please provide us with the contact details below of your previous surgery so that we can obtain a copy. Thank you

GP Practice Name: ……

GP Practice contact number: ……...