# Little Bushey Surgery

**CHILD REGISTRATION (Under 16)**

We need to make sure we have all the important contact information and health information about your child to register them. Please complete the following carefully and **PRINT CLEARLY**

**When registering a child, please bring child’s birth certificate and the red book or immunisation records book**

**If you are a new family registering we will need to see:**

* Your CHILD’S birth certificate
* YOUR photo I.D. (i.e. Passport/Driving Licence)
* YOUR Proof of address (i.e. Utility bill/Bank statement (in last 3 months)/Tenancy agreement

*Please speak to us if you have difficulty obtaining these documents*

## about your child

|  |
| --- |
| Surname: |
| Forename: |
| Gender: Male  Female  |
| Date of Birth: Place of Birth: |
| Address: |
| Home Tel : NHS Number:  Mobile No: Other Contact No: |
| Last UK Address: |
| Date of Arrival in UK (If applicable): |
| If previously resident In UK, please give date of departure: |
| Name & Address of  previous GP: |

The practice collects information about our patients’ ethnicity. This information will help us learn more about the health needs of our local community and allow us to plan services. All the information we receive will be used and treated with the strictest confidence.

|  |
| --- |
| What is the Ethnic Background of your child? |
| What is the MAIN Spoken language of your child? |
| Do you require an interpreter? Y  N  |
| **Do you need any specific communication support or need information in any particular format**  *YES*  *NO*   If yes, please give details: |

## 

|  |
| --- |
| Has your child had any serious illnesses or operations? *YES*  *NO*   If yes, what was this and when? Please give details: |
| Does your child have a disability or chronic condition? *YES*  *NO*   If yes, please give details: |
| Is your child on any regular medication? *YES*  *NO*   If yes, please tell us the name and dose: (if you have a list from your previous GP please give us a copy) |
| Is your child allergic to any medication? *YES*  *NO*   **If yes, please state type and name:** |
| Which school or nursery does your child attend? |
| Does your child have contact with any of the following? (If so please can you tell us their names) A hospital specialist YES  *NO* (please tick)  A health visitor YES  *NO* (please tick)  A social worker? YES  *NO* (please tick)  Any other health professionals YES  *NO* (please tick) |
| Has your child ever been under a Child Protection Plan? *YES*  *NO* (please tick)   |

## 

## about you (Parent or Guardian)

|  |  |  |
| --- | --- | --- |
| Name of Parent/Guardian Registering Child: | | |
| Mother’s Name: | | |
| Mother at same address? Yes  No  Mother registered at this practice? Yes  No   If other, please give details: | | |
| Father’s Name: | | |
| Father at same address? Yes  No  Father registered at this practice? Yes  No   If other, please give details: | | |
| Who is the PRIMARY carer? Mother  Father  Both   Other   If other, please give details: | | |
| Who has parental responsibility? Mother  Name:  Father  Name:  Other  Name:  If other, please give details:  (If above information has not been provided, then only the  mother can bring her child in for vaccinations)  **This will usually be the mother and**  **- the father if married to the mother**  **- the father if named on the birth certificate**  **- the father if he has a responsibility agreement/court order**  - the step father if he has a responsibility agreement/court order | | |
| Name & Address  of Current School or Childminder :  (If Applicable) | | |
| Please list the names of other household members living within the household:  For example siblings, relatives or friends. | | |
|  | Name | Relationship |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |

**Summary Care Records** are an electronic record of your child’s Medications and allergies that can be accessed (with your consent) in the event of an emergency (for example at an A&E Department).

If you wish to opt out of having a SCR, please complete the attached form. This can be done at any time. For more information on summary care record, please visit [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk)

***SMS messaging:***

*If you* ***do not*** *wish to receive SMS text messages from the surgery please tick this box* ***Opt Out of SMS***

The information you have provided will be kept in strictest confidence under the Data Protection Act

**Parent or Guardian’s Signature**: **Date:**

