**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**

**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)

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

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

about your child

The practice now 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 |
| What is your religion? |

## 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  Father  Both  Other  If other, please give details: |
| Do you have a family Social Worker? Yes  No  If Yes, please supply details: |
| Please list the names of other household members living within the household:  For example siblings, relatives or friends.  Name Relationship |

## Your child’s communication needs

From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard.

The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services.

Does your child:

have difficulty hearing, need hearing aids or need to lip-read what

people say? Y  N

have difficulty with memory or ability to concentrate, learn or understand? Y  N

have difficulty speaking or using language to communicate or make their

needs known? Y  N

have any special communication requirements or specific communication support?

Sign Language: British  Makaton  Tadoma  Other

## Your child’s immunisations

If your child is 0-5 yrs please provide us with information about any immunisations your child has received. .

Are there any vaccinations you do not want your child to have? Yes  No

Please let us know which these are:

If you wish to discuss vaccination please feel free to speak to one of our Nursing Team or see the Immunisation website at [www.nhs.uk](http://www.nhs.uk)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Age Due | Vaccine | Tick if Given | Date Given | At A GP Surgery | At Other Place |
| Birth onward | BCG  Hepatitis B (course of 4 injections  At birth, 1, 2 and 6 months) |  |  |  |  |
| 2 months | 1st DTP & Hib & Polio  1st Pneumococcal |  |  |  |  |
| 3 months | 2nd DTP & Hib & Polio  1st Meningitis C |  |  |  |  |
| 4 months | 3rd DTP & Hib & Polio  2nd Meningitis C & 2nd Pneumococcal |  |  |  |  |
| 12 months | 1st MMR, Hib & Men C Booster  3rd Pneumococcal |  |  |  |  |
| 15 months | 2nd MMR (or 3 mths after 1st MMR ) |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 3yrs 4 months | Dip/Tet/Pertussis + Polio booster |  |  |  |  |

What is the best way to send you information?

Telephone  SMS  Letter  Email

There are occasions when it might be necessary to contact you via telephone, text message or email regarding clinical or administrative matters. Please confirm which would be acceptable:

I AGREE I DO NOT AGREE TO THE PRACTICE:

LEAVING MESSAGES ON MOBILE/HOME TELEPHONE

I AGREE I DO NOT AGREE TO THE PRACTICE CONTACTING ME VIA EMAIL

I AGREE I DO NOT AGREE TO THE PRACTICE CONTACTING ME VIA SMSTEXT

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

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

STAFF USE ONLY:

Birth Cert & ID Verified Y  N

Staff Initial

Adult Registering Child has Parental Responsibility? Y  N

Name of Local Authority confirmed if child has social worker Y  N

***AND added to new pt template under “Social Worker”***

AND patient emis alert added showing SW/Borough

Child under 5 – Details passed to HV Team Y  N

