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UNDER 16 New Registration Form

We are pleased that you have applied to register your child with this practice. By providing the following information you will help us to understand his/her medical requirements as well as assisting us with the registration process. The information you give will be treated in the **STRICTEST CONFIDENCE**. Together with this sheet you should have been offered a *Practice Brochure* describing the services we offer, if not please request one. Please complete this form as fully as possible and return it to reception. Please note that your child is **NOT** registered with this practice until a doctor has agreed to take him/her onto the practice list.

DATE

NAME		
FIRST (Christian) NAMES	SURNAME/FAMILY NAME	SEX MALE/ FEMALE

DATE OF BIRTH DAY / MONTH / YEAR	NHS Number (if known)
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ADDRESS _____ Post code Tel Number	SCHOOL PRESENT PREVIOUS _____ _____
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Who else lives at this address with your child?

Your Child's Previous Address:	Name & Address of last GP
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Next of Kin/Guardian :

Relationship :	Name _____
	Address _____ _____
	Tel No. _____

PERSONAL HEALTH

Please list any serious illnesses, hospital admissions or operations your child has had

Year	Hospital	Nature of Illness/Operation

Please tick here if your child has no significant history or problems

Does your child have or has he/she had any of the following problems? (Please circle)

Asthma

Diabetes

Learning Difficulty

PLEASE TICK HERE IF YOUR CHILD DOES NOT TAKE ANY REGULAR MEDICATION

MEDICATION

PHARMACY

Does your child take any medication regularly (please bring labelled containers), if so, please list :

Your child's allergies:

Your child's sports/hobbies:

FAMILY MEDICAL HISTORY

Please enter details of any major illnesses in family members:

Your Child's Birth History:-

Place of Birth :-

Birth Weight :-

Type of Delivery : please circle

Normal

Forceps

Caesarean Section

Intensive Care after delivery

Yes / No

Breast Fed

Yes / No

How long?

Previous Immunisations:

Please state how many and dates if possible

Polio	Yes / No
Diphtheria	Yes / No
Tetanus	Yes / No
Pertussis (Whooping Cough)	Yes/ No
HIB	Yes / No
Meningococcal C	Yes / No
Pneumococcal	Yes / No
Measles	Yes / No
Mumps	Yes / No
Rubella	Yes / No
TB (Tuberculosis)	Yes / No
Hepatitis A	Yes / No
Hepatitis B	Yes / No

Does your child have any current health problems?

Ethnic

Please indicate your child's ethnic origin by ticking the box which most closely reflects his/her background.

White			
Scottish .9S13	<input type="checkbox"/>	British .9S10	<input type="checkbox"/>
Irish .9S11	<input type="checkbox"/>	Other White background .9S12	<input type="checkbox"/>
Asian, Asian Scottish or Asian British			
Indian .9S6	<input type="checkbox"/>	Pakistani .9S7	<input type="checkbox"/>
Bangladeshi .9S8	<input type="checkbox"/>	Other Asian background .9SH	<input type="checkbox"/>
Black, Black Scottish or Black British			
Caribbean .9S2	<input type="checkbox"/>	African .9S3	<input type="checkbox"/>
Other Black background .9SG	<input type="checkbox"/>		
Chinese .9S9	<input type="checkbox"/>		
Mixed			
White & Black Caribbean .9SB5	<input type="checkbox"/>	White & Black African .9SB6	<input type="checkbox"/>
Other Mixed background .9SB4	<input type="checkbox"/>	White & Asian .9SB2	<input type="checkbox"/>
Any other background .9SJ	<input type="checkbox"/>		

If you do not wish to state your child's ethnic background please tick this box .9SD

Please state your preferred language

Will you require an interpreter when you consult the doctor or nurse? Yes No

Practice use only :

Weight

Urinalysis (multistix)

Height