New Patient Questionnaire – Child

If you are registering with the Practice and you have a child under the age of 16 years, please could you give the following details and complete the Previous Immunisation and medication section on the back for each child registering.

Child's full name:			
Child's date of birth:	(format DD/MM/YY)		
Address:			
Parent's email			
We may occasionally communicate with you by SMS or email. We will not pass your email address or phone number to any non-NHS organisation. Tick here if you do **NOT** wish to be contacted by email or SMS. ☐			
Parent / Guardian details			
Parent 1: (ie. Mum)			
Parent 1 telephone number:		Their date of birth:	
Parent 2: (ie. Dad)			
Parent 2 telephone number:		Their date of birth:	

Child's Family History

Have any close family (parents/brother/sister) had any of these illnesses or conditions?

		Details, for example Father, Mother, Sister
☐	Raised cholesterol	
☐	Stroke	
☐	Heart disease before the age of 60	
☐	Heart disease after the age of 60	
☐	Asthma	
☐	Cancer	
☐	Diabetes	

Child's Past medical history

Please list with dates any **significant** current or past illnesses, operations or allergies. **SEE PAGE TWO FOR REPEAT MEDICATION**

CHRONIC ILLNESS, OPERATION OR ALLERGY	DATE

Child's Height / Length _____ **Child's weight** _____

Child's Ethnicity

Child's country of birth? _____ **Child's first language?** _____

How would you describe the Child's Ethnicity _____

Summary Care Record – Please read attached information sheet before answering the following question.

SCR Consent *(Please select one box only)*	☐ Express consent for medication, allergies and adverse reactions only
	☐ Express consent for medication, allergies, adverse reactions and additional information
	☐ Express dissent – Does not want a Summary Care Record ***(please also sign separate disclaimer for this)***
Signed on behalf of child:	

Previous Childhood Immunisations – ESSENTIAL for under 5's

Is your child up to date with his/her vaccinations? Please list below when and where they were done.
If they are not up to date or you are not sure, please call the surgery to discuss your needs with the Nurse.

VACCINATION	DATE (DD/MM/YY)	NAME OF GP / Country
1ST DTaP / IPV / HIB		
2nd DTaP / IPV / HIB		
3rd DTaP / IPV / HIB		
1st Pneumococcal		
2nd Pneumococcal		
3rd Pneumococcal		
1st Meningitis B		
2nd Meningitis B		
3rd Meningitis B		
1st Rotavirus		
2nd Rotavirus		
1st Men C		
2nd Men C		
HIB / Men C Booster		
Single HIB		
1st MMR		
2nd MMR		
Pre School Booster (DTaP / IPV) (31/2 yrs)		
1st Hepatitis B		
2nd Hepatitis B		
3rd Hepatitis B		
1st Hepatitis A		
2nd Hepatitis A		
BCG		
HPV		
OTHER IMMUNISATION:		

* IMPORTANT - IF YOUR CHILD TAKES REGULAR MEDICATION – PLEASE LIST HERE *	
MEDICATION	**DOSE**

Signed _____

Relationship to child _____

Does your child have any information or communication needs we should know about? ☐ Yes ☐ No

For example - Documents in large print, a sign language interpreter, use of our hearing aid loop ?
Please let us know if we can help you.

Nominated Pharmacy

Which Pharmacy do you normally use? _____

Would you like your prescriptions to be sent to them electronically? ☐ Yes ☐ No You will need to register with the selected pharmacy for this service.

Or Alternatively

Would you like to collect your prescriptions from the Surgery yourself? ☐ Yes ☐ No

Which Surgery would you like to collect your prescriptions from? ☐ Gervis Road ☐ St Leonard's Road