NEW PATIENT QUESTIONNAIRE – CHILD

If you are registering with the Practice and you have a child under the age of 16 years, please complete **BOTH** pages for each child registering. Please provide a full copy of all immunisations.

CHILD'S DETAILS

Child's First name	
Child's Middle name	
Child's Family/surname	
Child's Date of birth	(Day/Month/Year)
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 name:			
Date of birth:		Phone number:	
Parent 2 name:			
Date of birth:		Phone number:	

CHILD'S FAMILY HISTORY

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

MEDICAL CONDITION (please tick)	**DETAILS** (Father, Mother, Sister and type of cancer/diabetes)
☐ Raised cholesterol	
☐ Stroke	
☐ Heart disease before the age of 60	
☐ Heart disease after the age of 60	
☐ Asthma	
☐ Cancer	
☐ Diabetes	

CHILD'S MEDICAL HISTORY

LIST SIGNIFICANT CHRONIC ILLNESS, OPERATIONS AND/OR ALLERGIES BELOW	**DATE**
Does your child have any communication needs? (eg. documents in large print, sign language interpreter, use of our hearing aid loop. if so, please know if we can help you)	☐ Yes ☐ No Details:
What is your child's height / length?	
What is your child's weight?	

CHILD'S ETHNICITY

Child's Country of birth:		**Child's first language:**	
How would you describe your Child's Ethnic group?			

SUMMARY CARE RECORD

Please read attached information sheet before answering the following question. Please select one box only

SCR Consent	☐ 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)***
Sign here on behalf of child:	

PREVIOUS CHILDHOOD IMMUNISATIONS

Please list **ALL** immunisations below if your child was not given them at a UK GP surgery. Please also provide a translated copy of all immunisations if you have them. We will then contact you if your child needs any further vaccinations.

VACCINATION (UK SCHEDULE)	DATE (Day/Month/Year)	GP SURGERY / COUNTRY
1ST DTaP / IPV / HIB		
2nd DTaP / IPV / HIB		
3rd DTaP / IPV / HIB		
DTaP / IPV single booster		
1st Pneumococcal (Pneumonia)		
2nd Pneumococcal (Pneumonia)		
3rd Pneumococcal (Pneumonia)		
1st Meningitis B		
2nd Meningitis B		
3rd Meningitis B		
1st Rotavirus		
2nd Rotavirus		
HIB/Meningitis C Booster		
1st MMR		
2nd MMR		
1st Hepatitis B		
2nd Hepatitis B		
3rd Hepatitis B		
BCG		
PLEASE LIST ALL OTHER VACCINATIONS BELOW:	**DATE (Day/Month/Year)**	**GP SURGERY / COUNTRY**

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

NOMINATED PHARMACY

Which Pharmacy do you use? (e.g Boots in the square)	
Would you like your prescriptions to be sent to them electronically? (You will need to register with the pharmacy for this)	☐ Yes ☐ No
OR If you would like to collect your prescriptions from the Surgery yourself, which surgery would you prefer?	☐ Gervis Road ☐ St Leonard's Road

Signed: _____ **Name:** _____

Your relationship to child: _____ **Date:** _____