You are invited to have a consultation with a health care professional within 6 months of registering.

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| ABOUT YOUR CHILD |
| Surname: |  | Forename (s): |  |
| Gender: |  | DOB: |  |
| Address:  |  |
|  |
| Postcode: |  |
| Who has legal parental responsibility (i.e. both parents, mother, father, grandparents, other?) |  |
| Who does the child live with? |  |
| Which school does the child attend? |  |
| Are there any other important facts you feel we should know about your family? |  |

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| NEXT OF KIN |
| Name | Relation to your child | Contact Details |
|  |  |  |
|  |  |  |

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| ABOUT YOU |
| Surname: |  | Forename(s):  |  |
| Relationship to Child: |  |
| Email: |  |
| Home phone: |  |
| Mobile |  | Work Phone: |  |

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| ETHNICITY |
| **White**  |
| British Group  | [ ]  | Irish  | [ ]   | Other White Background | [ ]  |
| **Mixed**  |
| White & Black Caribbean  | [ ]  | White & Black African  | [ ]  | White & Asian  | [ ]  [ ]  | Other MixedBackground | [ ]  |
| **Asian or Asian British**  |
| Indian  | [ ]  | Pakistani  | [ ]  | Bangladeshi  | [ ]  | Other AsianBackground | [ ]  |
| **Black or Black British**  |
| Caribbean  | [ ]  | African  | [ ]  | Other BlackBackground | [ ]  |
| **Chinese or other ethnic Group**  |
| Chinese  | [ ]  | Any Other  | [ ]   |
| First Spoken Language:  |  |
| Do you require an interpreter: |  |

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| HEALTH CONDITIONS |
| *Has your child ever been diagnosed with:* | YES | NO |
| Asthma | [ ]  | [ ]  |
| Epilepsy | [ ]  | [ ]  |
| Diabetes | [ ]  | [ ]  |
| Deafness/hearing impairment | [ ]  | [ ]  |
| Blindness/visual impairments | [ ]  | [ ]  |
|  |
| *If your child has an conditions, please give details below:* |
| Learning/ behavioural difficulties |
|  |
| Heart/Lung/Kidney/Liver problems |
|  |
| Other Medical problems |
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| FAMILY HISTORY  |
| *Please indicate if either of your child’s parents or a sibling has been affected by:* |
|  | YES | Family Member | Age at onset |
| Heart attack/ Angina | [ ]  |  |  |
| Stroke | [ ]  |  |  |
| Diabetes | [ ]  |  |  |
| Hypertension (high BP) | [ ]  |  |  |
| High Cholesterol | [ ]  |  |  |
| Asthma | [ ]  |  |  |
| CancerType of Cancer ……………………………………...........……………………………………………………………………………………………………………………………… | [ ]  |  |  |

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| ALLERGIES/ INTOLERANCES |
| *Please list any drugs, food or other substances to which your child is allergic (i.e. develop an rash/swelling/anaphylactic shock) or drugs to which they are intolerant (i.e. side effects such as diarrhoea or nausea)*  |
|  | Allergy / intolerant (please circle) |
|  | Allergy / intolerant (please circle) |
|  | Allergy / intolerant (please circle) |
|  | Allergy / intolerant (please circle) |

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| MEDICATIONS |
| *Please provide a list of any repeat medications your child Is taking:* |
| **Your child will need to see a GP before we can issue any medications that were on repeat at your previous GP** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

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| PRESCRIPTIONSBinscombe Medical Centre is an electronic prescribing practice. If you would like to nominate a pharmacy for this service you can do so through your chosen pharmacy. You can find a list of local pharmacies on the NHS Choices website at www.nhs.uk. |

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| IMMUNISATIONS |
| Are your child’s vaccinations up to date? | YES [ ]  NO [ ]  |
| *If you are unsure please make an appointment with the practice nurse or supply a copy of vaccination records, if their vaccinations were given overseas please provide a translation.* |

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| YOUNG CARERS |
| Is your child a young carer? | YES [ ]  | NO [ ]  | If yes, please ask for a carers form when you hand in this form |
| *(Do they look after someone who is dependent on them some, or all of the time?)* |

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| CONSENT FOR COMMUNICATION FROM US |
| At Binscombe, we use texts and emails to keep you informed about your care and the practice. |
| **If you have provided a mobile phone number for your child in this questionnaire it will automatically be used to enrol your child in our text service which allows you to receive messages about their care such as appointment reminders and vaccination invitations.** |
| If you **DO NOT** wish to receive these text messages, please tick this box | [ ]  |
| *Please be aware that if you opt-out you will not receive appointment reminders* |
|  **If we need to contact you about other aspects of your childs care:** |
| Are you happy for us contact you via email? | YES [ ]  | NO [ ]  |
| Are you happy for us to contact you via text message? | YES [ ]  | NO [ ]  |
| Are you happy for us to leave a message on your answerphone? | YES [ ]  | NO [ ]  |
| Are you happy for us to contact you by the above methods to keep you the surgery e.g. newsletters | YES [ ]  | NO [ ]  |
| *You may opt in or out of communication services at any time by contacting the surgery.* |
| *Do you or your child have any disability or individual need that might affect how we should contact you? (e.g. hearing impairment, visual impairment, difficulty readying) Please detail below:* *………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………* |

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| SUMMARY CARE RECORD |
| **This practice participates in** the national Summary Care Record programme which enables each patient to have a summary of their key medical information held securely on the NHS central database, known as the NHS Spine. This summary record could be used in an emergency if you needed treatment when access to the medical record held by your GP was not available; for example if you call the doctor out of hours. You will always be asked to give permission for this record to be viewed and you have the right to decline. If you decide to have a Summary Care Record it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. |
| If you ***do not*** wish your child to have a summary care record, please indicate below |
| I do not wish my child to have a summary care record ……………………………………………………….[ ]  |

**Under NHS Regulations, we cannot accept registrations that are incomplete.**

To prevent a delay in your registration being accepted please read the guidance below before filling in the attached forms:

* All patients will need to provide a copy of their Passport/ Visa and a copy of a utility bill for proof of address
* If you are from abroad, we will require Date of Entry to the UK
* If previously resident in the UK we will also require Date of Leaving UK and Date of Entry
* Please provide full details of your previous address including postcode. This is particularly important if previous address was in London.

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| Parent/Guardian Signature: |  | Date: |  |
| Print Name: |  |  |  |