Pre-registration Child Health Assessment Form

All information given on this form will be added to your medical record therefore it is important that this form is completed as fully as possible.

Have you previously been registered at the Practice?	Yes	No
Approximate Date Left the Practice		

Surname		**Sex**	Male Female Other
First Name		**Child's Nursery/School or College details**	
Date of Birth			
Address			
Home Telephone		**Mobile Telephone**	
Please give details of adults with parental responsibility (Title, First Name & Surname)		**Relationship**	
		Relationship	

The practice provides an automated text message service. This is primarily used to send automated appointment details and communication relating to your individual care. We do not participate in any form of marketing.

Are you happy to receive text messages directly from the Practice?	Yes	No

The NHS **Summary Care Record** (SCR) is an electronic **summary** of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP **record**. It is used by authorised healthcare professionals, with the patient's consent, to support their **care** and treatment.
More information is available www.digital.nhs.uk/services/summary-care-records-scr

Do you agree for your information to be included in the Summary Care Record?	Yes	No

Your Child's Health

Child's Height		**Child's Weight**	

Does your child have any significant medical conditions at present?	Yes	No

Please give details:

Does your child take any regular medication? (Please specify medication and dose below, and if possible please supply a print out of your current medication from your previous GP practice)	Yes	No

As we do electronic prescribing, please make sure to write in this box your nominated pharmacy, where you would like us to send your prescriptions to:

Pharmacy Name:
Address:

Medication	**Dose**	**Medication**	**Dose**

Does your child have any allergies to medication? (Please provide details)	**Yes**	**No**

Allergies:

Please provide any information about vaccinations (with dates if possible)
(if you have your child's Child Health red book please bring it with you when registering.

We will not be able to fully register your child until we have details of all their vaccinations

Please can you tell us which vaccinations your child has had and give the date of each:

Family History

Please give details of any significant family illness (including what relationship they are to you)

Patient Ethnic Origin Questionnaire

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your health care, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E and tick ONE box to indicate your background

A) **WHITE**		**Please State your first chosen language:**
	British	
	Irish	
	Any other background	Please specify:
B) MIXED		
	White & Black Caribbean	
	White & Black African	
	White and Asian	
	Any other background	Please specify:
C) ASIAN OR ASIAN BRITISH		
	Indian	
	Pakistani	
	Bangladeshi	
	Any other Asian background	Please specify:
D) BLACK OR BLACK BRITISH		
	Caribbean	
	African	
	Any other black background	Please specify:
E) OTHER ETHNIC GROUP		
	Chinese	
	Any other ethnic background	Please specify:
NOT STATED		
	Not stated	

Parent/Guardian Signature ____ **Date** ___________________________

Please bring this completed form with you in order to register you with the practice