

New Child Patient (Age 0 - 6) *evolution* health **NHS**

Please complete the following information on behalf of your child and hand your form in to a member of reception staff. All information is kept strictly confidential. You cannot register a child with the practice if you, as their parent or legal guardian, are not also registered at this practice. This helps us to provide efficient care for your child.

Patient Details

Male Female

Surname

Forename

DOB

NHS Number

Parent / Guardian Details

Name

Relationship to Child

Email

Address

Postcode

Phone

Contact me via email/text

Ethnicity

- White
 White British
 White Irish
 White Other

- Black
 Caribbean
 African
 Black Other

- Other Ethnic Groups
 Chinese
 Any other Ethnic Group

- Mixed
 White and Black Caribbean
 White and Black African
 White and Asian
 Mixed Other

- Asian or Asian British
 Indian
 Pakistani
 Bangladeshi
 Asian Other

I do not wish to state my ethnicity

First Language (Children and babies ethnicity and first language will be defined as Parent/Guardian)

- Arabic
 British Signing Language
 English
 French
 Hindi

- Urdu
 Bengali
 Tigrinya
 Spanish
 Chinese (Cantonese/Mandarin)

Other (please specify below)

Child Protection

Which school does your child attend?

Has your child ever been on the child protection register?

Medication

Is your child on any medication? If so, please specify below.

Name of Medication e.g. Metformin

Dose e.g. 500mg

How many per day e.g. 3 tablets p/day

Allergies

Does your child have any allergies to the following? If so, please tick where appropriate.

Other

Pollen (Hay Fever)

Medicine e.g. Penicillin

Cosmetics

Nuts

Dairy

If you ticked any of the boxes above, please give detail below.

Operations

Has your child had any operations?

Name of Operation

Name of Hospital

Approximate Date

Family History

Is there any family history of the following medical conditions? If so, please tick below.

Asthma Diabetes Hypertension Heart Disease CVA / Stroke Epilepsy Cancer

If you ticked any of the boxes above, please give detail below.

Immunisations

If your child had immunisations at your last surgery then please provide:

Name of Surgery

Address

Postcode

Do you have a 'red book' showing immunisation details? Y N

**IMPORTANT
PLEASE BRING IN
YOUR RED BOOK**

If no, then please add your child's immunisation details in the table below:

	2 Months	3 Months	4 Months
Diphtheria, Tetanus, Pertussis (DTP), Hib & Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningitis C	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hib & Meningitis C	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal	<input type="text"/>	<input type="text"/>	<input type="text"/>
MMR	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diphtheria, Tetanus, Pertussis & Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>
MMR	<input type="text"/>	<input type="text"/>	<input type="text"/>

I

Mother / Father of

confirm that all information given is correct and completed to the best of my ability.

PLEASE SIGN IN THE BOX