Collection fields to be trialled at registration of child or young person under 18 years of age.

REGISTRATION FORM FOR CHILD OR YOUNG PERSON

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| Surgery Details: | | | Date form completed:  NHS Number if known: |
| **Details of child being registered** | | | |
| Surname: | | | Forename(s): |
| Date of Birth : | | | Sex: Male / Female |
| Current Address :  Post Code : | | | Contact details  Home Tel.:  Mobile No: |
| First language spoken: | | | Religion: |
| Ethnic origin: | | | Place of birth: |
| Name of School/Nursery | | Has the child been known by any other name : YES /NO  If yes please give details: | |
| Name and address of previous GP: | | | Previous address if from abroad:  Date first came to UK: |
| **Details of Childs Main Carer:** | | | |
| Surname: | First Name: | | |
| Current address (if different from child’s): | Contact details (if different from above): | | |
| What is your relationship to the child: (ie Mother, father - specify) | Consent to be contacted by text message Yes/No | | |
| **Does the child have contact with the father : YES / NO** | | | |
| Surname: | | | First Name: |
| Current address (if different to child’s): | | | Contact details (if different to child) |

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| Childs Surname: | Childs Forename: |
| **Any other significant carers involved in the upbringing of this child or young person (eg Stepfather, aunt, grandparent or Foster carer)**  If yes please give details: | |
| **Are any other services known or involved with family or young person**? Eg Social Care, CAMHS: YES / NO  If yes, please give details : | |
| **Does the child have any disabilities or distinguishing features**? YES / NO  If yes, please give details: | |
| **Please state any significant medical history** :  **Is the patient on any repeat medication**? YES / NO  If yes please give details:  **Does the child suffer from any allergies**? YES / NO  If yes please give details:  **Is there any significant family history**? ie. Asthma/Heart conditions | |
| Is the child or YP a smoker?: YES / NO | Does the child consume alcohol? YES / NO |

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| HOUSEHOLD COMPOSITION  Please list all persons (adults and children) who live at the address with this child | | | | | |
| Surname | First Name | DOB | Occupation/School/  Nursery | Relationship to child ie. Sibling/aunt etc | Registered at surgery  (Yes/No) |
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