

Registration Questionnaire
CHILD AGED UNDER 16

Child's Details			
Forename		Surname	
Date of Birth		Age	
Birth Town		Birth Country	
NHS Number		Ethnic Origin	
Playgroup, Nursery or School			
Home Address			
Postcode			
Patient's Mobile Tel No. (if aged 14yrs+)		Home Tel No.	
Mother's Mobile No.		Father's Mobile No.	
Next of Kin		Relationship to Child	
Parents' Details			
Mother's Full Name:		DOB:	
Father's Full Name:		DOB:	
Previous Home Address			
Post Code:			
Previous GP		Previous GP Surgery Address	

Child's Medical History	
Please list any serious illness, accidents and hospital admissions for operations, with dates if possible and also list any present illnesses or medical conditions.	
Please list any drugs, tablets or medicines the child is currently taking.	
Is the child allergic to any tablets or substances?	YES /NO If yes, which ones?

Has your child had the following vaccinations?

Age Due	Immunisation	Comments	Date Given
2 months	Diphtheria / tetanus / whooping cough, Polio Hib and Pneumococcal infection and rotavirus and Men B (Sept 2015)		
3 months	Diphtheria / tetanus / whooping cough, Polio Hib, Meningitis C and rotavirus		
4 months	Diphtheria / Tetanus / Whooping cough, Polio Hib Pneumococcal infection and Men B (Sept 2015)		
Around 12 months	Hib and Meningitis C		
Around 13 months	Measles, Mumps, Rubella (German Measles) Pneumococcal infection and Men B booster (after Sept 2015)		
3 years and 4 months or soon after	Diphtheria / tetanus / whooping cough, polio, measles, mumps and rubella		
Girls 12-13 years	Cervical cancer caused by human papillomavirus types 16 & 18		
14 years	Tetanus, diphtheria and polio & Men C		
	Non-routine immunisations for at risk babies		
At birth	Tuberculosis. BCG (to babies who are more likely to come into contact with TB than the general population)		
At birth	Hepatitis B (Hep B) (to babies whose mothers have hepatitis B)		

I do / do not* consent to information that identifies my child to be shared outside of their GP practice (other than where necessary by law, e.g. if there is a public health emergency).

Signed

Date

For Children aged under 5yrs:

Previous Health Visitor	
Birth Weight	
Were there any problems with the pregnancy or birth?	YES / NO If yes, please give details:

For children aged under 5yrs: THIS FORM WILL BE GIVEN TO THE FLEET HEALTH VISITORS

Office Use Only	
Type of ID provided	
ID Checked by	
Entered by	
Patient consents to electronic record sharing Read code: 'Initial SCR Consent' 9Nd7	Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient does not consent to electronic sharing Read code: 'Opt out' 9Nd1	Yes <input type="checkbox"/> No <input type="checkbox"/>