

## **CHILD REGISTRATION FORM (age Under 5s)**

**Please print clearly**

Date \_\_\_\_\_

Surname \_\_\_\_\_ First Name/s \_\_\_\_\_

Date of Birth \_\_\_\_\_ Tel. Number \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

**Child's ethnic group (Please tick one)**

British/Mixed British  Irish  Other White background  White & Black Caribbean

White & Black African  White & Black Asian  Other Mixed Background

Indian/ British Indian  Pakistani/British Pakistani  Bangladeshi/British Bangladeshi

Other Asian background  Caribbean  African  Other Black Background  Chinese

Other ethnic group (please give details) \_\_\_\_\_ **Full**

**name of Parents / Guardians** \_\_\_\_\_

Please confirm who has parental responsibility

Joint          Mother only          Father only          Guardian

**Tel. Number of Parent / Guardian (if different)** \_\_\_\_\_

**Name and address of current nursery school** \_\_\_\_\_

\_\_\_\_\_

**Name of previous Health Visitor:** \_\_\_\_\_

**Have you ever been seen by a doctor or nurse at this surgery before?**          Yes / No

**Vaccinations**

**FOR ANY UK VACCINATIONS WE NEED TO SEE THE CHILD'S RED BOOK.**

**FOR ANY VACCINATIONS THAT HAVE BEEN GIVEN OVERSEAS WE REQUIRE DOCUMENTATION SHOWING DETAILS OF THESE VACCINATIONS AND THE DATES. AN APPOINTMENT IS TO BE BOOKED WITH THE NURSE TO DISCUSS THESE VACCINATIONS TO ENSURE VACCINATIONS ARE UP TO-DATE.**

**Medical History**

**Do you suffer from: (please circle)**

Asthma    Yes / No          Cancer    Yes / No

Diabetes    Yes / No          Epilepsy    Yes / No

Heart Disease	Yes / No	High Blood Pressure	Yes / No
Hypothyroidism	Yes / No	Mental Health Problems	Yes / No
Respiratory Diseases	Yes / No	Strokes	Yes / No

**Have you ever had any other operations or illnesses (e.g. tonsils removed etc.) Yes / No**

If Yes, (please list below and give dates where possible)

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**Family History**

Has anyone in your immediate family suffered with: (please circle)

Asthma	Yes / No	Cancer	Yes / No
Diabetes	Yes / No	Heart Attack	Yes / No
High Blood Pressure	Yes / No	Stroke	Yes / No
Other	_____		

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**General Health and Social History** (please circle)

Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you have any allergies? (e.g. aspirin, penicillin) No / Yes (give details) \_\_\_\_\_

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Are you on any regular medication?

No / Yes (give details)

1. \_\_\_\_\_  
3. \_\_\_\_\_

2. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

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**Office use only**

Urine \_\_\_\_\_

Blood Pressure

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Smoking Cessation Advice given                      Yes / No

Data Sharing: You hold the key and you can decide what information you share and who you share it with. We have attached an information sheet, opt out form and leaflet which will help you decide.