REGISTRATION FORM FOR CHILD OR YOUNG PERSON (<18years)

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| **Surgery Details:** **Peacock Surgery** | 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 or Preferred language spoken: | Religion: |
| Ethnic origin: | Place of birth: |
| Name of School/Nursery | Has the child been known by any other name : YES /NOIf yes please give details: |
| Name and address of previous GP: | Previous address:Date first came to UK (if from abroad: |
| **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 if mother is the main carer Or mother if father is the main carer or both if main carer is aunt/granny etc** |
| 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 / NOIf yes, please give details : |
| **Does the child have any disabilities or distinguishing features**? YES / NOIf yes, please give details: |
| **Please state any significant medical history** :**Is the patient on any repeat medication**? YES / NOIf yes please give details:**Does the child suffer from any allergies**? YES / NOIf 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 or YP 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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