*Dr Green, Dr Kutty, Dr Giffen,* *Dr Hold, Dr Machin, Dr Parsons, Dr Robinson, Dr Mifflin*

***New Baby Registration Form***

**Biddulph Valley Surgery**

**Tel:** 0300 404 2987

Email:ssicb.nst.biddulphvalleysurgery@staffs.nhs.uk

**Website:** www.biddulphvalleysurgery.nhs.uk

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| --- |
| **Please complete in BLOCK CAPITALS.****\*\*\*COPY OF BIRTH CERTIFICATE REQUIRED FOR GP RECORDS \*\*\*** |

**NHS Number ................................................**

**Date of Birth ................................................**

**Child’s Name ................................................**

**Sex ................................................**

**Ethnic Origin ................................................**

**Main Spoken ................................................**

**Language**

**Place of Birth .................................................**

**Preferred Nominated Chemist …………………………….**

*Your Data Matters to the NHS.*

*Information about your health and care helps us to improve your individual care, speed up diagnosis, plan your local services and research new treatments.*

*In May 2018, the strict rules about how this data can and cannot be used were strengthened. The NHS is committed to keeping patient information safe and always being clear about how it is used.*

*You can choose whether your confidential patient information is used for researching and planning.*

*To find out more visit:*

*nhs.uk/your-nhs-data-matters or phone 0300 303 5678 Monday to Friday, 9am to 5pm*

**Signature: ............................................**

**To Be Completed by the Person Registering the Child**

**ADDRESS ..................................................**

 **..................................................**

 **..................................................**

**POSTCODE .......................**

**TEL. NUM ..................................................**

**SIGNATURE ..................................................**

**RELATIONSHIP .........................................**

**DATE .........................................**

**Are you happy to receive Text Messages from Biddulph Valley Surgery using the mobile number provided *(For example: Appointment booking confirmation, appointment cancellation, health promotion e.g. flu season vaccination appointments, important information for patients)*:** YES/ NO

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| --- |
| ***Office Use Only*** |

**I am willing to accept the applicant as a registered NHS patient.**

**.......................................................................**

**Authorised signature (on behalf of the practice) ..........................................**

**Print: .......................................... Date: ..........................................**

Forms Accepted By:

Registered By (if different to above):

Copy of Birth Certificate:

Biddulph Valley Surgery Stamp:

**\*PLEASE ALSO COMPLETE THE CONSENT FOR IMMUNISATIONS FORM BELOW\***

**Parental Responsibility Consent for Childhood Immunisations**

**As you are aware you will shortly be bringing your child for their routine immunisations with our Practice Nurse here at the surgery. The first immunisation appointment for baby will be with the nurse, followed by an 8 week check with the GP straight after.**

**We will need signed consent from the Mother or Father (but only if he has Parental Responsibility ie named on birth certificate) before any immunisations can be given to your child. This form can also authorise another family member to bring the child for future immunisations if you have signed initially. This form will be kept on your child’s records for use in future if needed. You can change your mind anytime about the consent that you have given to these routine immunisations by contacting the practice.**

**I hereby give permission for my child……………………………………………………………………. DOB………………………**

**To have the following Immunisations**

 **Signature……………………………………………. Relationship to child………................................... Date……………….**

|  |  |  |
| --- | --- | --- |
| **AT WHAT AGE TO IMMUNISE** | **DISEASES PROTECTED AGAINST** | **V ACCINE GIVEN** |
| **8 weeks old** | Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenza type b (Hib) & hepatitis BMeningococcal group B (MenB)Rotavirus-gastroenteritis | DTaP/IPV/Hib/HepB(Thigh)Men B (Left thigh)Rotavirus (By mouth) |
| **12 weeks old** | Diphtheria, tetanus, pertussis, polio, Hib & Hepatitis BPneumococcalRotavirus  | DTaP/IPV/Hib/HepB(Thigh)PCV (Thigh)Rotavirus (By mouth)  |
| **16 weeks old** | Diphtheria, tetanus, pertussis, polio, Hib & hepatitis BMeningococcal group B (MenB) | DTaP/IPV/Hib/HepB (Thigh)Men B (Left thigh) |
| **One year old (on or after the child’s first birthday)** | Hib/Meningococcal group C (MenC)Pneumococcal Measles, mumps and rubella (German Measles)Meningococcal group B (MenB) | Hib/Men C (Upper arm or thigh)PCV booster (Upper arm or thigh)MMR (Upper arm or thigh)Men B booster (Left thigh) |
| **3 years four months old or soon after** | Diphtheria, tetanus, pertussis and polioMeasles, mumps and rubella | DTaP/IPV (Upper arm)MMR (Upper arm) |