**HEATH HAYES HEALTH CENTRE / CHASE MEDICAL PRACTICE**

**Phone: 01543 577752 Email:reception.hhcm@staffs.nhs.uk**

**Please bring the child’s Red Book with you so we can take a copy of their immunisation record.**

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| **CONFIDENTIAL MEDICAL REGISTRATION FORM (Children Under 16)** |
|  |
| **Child’s Personal Details:** |
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**Please complete all pages in FULL using BLOCK capitals**

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| --- | --- |
| Child’s Surname: |  |
|  |  |
| Child’s First Names (in full): |  |
|  |  |
| Previous Surnames: |  |
|  |  |
| **Title:** | ❒ Master ❒ Miss ❒ Ms ❒ Male ❒ Female |
|  |  |
| Date of Birth (day/month/year): |  |  |  |  |  |  | NHS Number:(if known) |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Town & Country of Birth: |  |
|  |  |
| Address: | Post Code:  |
|  |  |
| Telephone Number: |  | Mobile Number1: |  |
|  | 1  Note, we use the mobile number for text messages. |
|  |  |  |  |
| Email Address2: |  |
|  |  |
| 2  Please specify whose above email address this is, e.g. parent, guardian etc. |  |
|  |  |
| **Name of Parent(s) / Carers** | **Has Legal / Parental Responsibility?** | **Next of Kin?** |
| 1.
 |  ❒ Yes ❒ No |  ❒ Yes ❒ No |
| 1.
 |  ❒ Yes ❒ No |  ❒ Yes ❒ No |
| If not the above, name of person with legal responsibility: |  |
| Contact details of person with legal responsibility |  |
|  |  |
| **Does the child have any special communication / mobility needs?** ❒ Yes ❒ No**If yes:** ❒ Wheelchair ❒ Walking Aid ❒ Hearing Aid ❒ Large Print  ❒ Lip Reading ❒ Braille ❒ British Sign Language  ❒ Makaton Sign Language ❒ Other: ….………………………………….. |
|  |
| **Is the child currently:** ❒ A Refugee ❒ An Asylum Seeker**Is the child a child in care?** ❒ Yes ❒ No**Is the child a “Looked After Child”?** ❒ Yes ❒ No**If yes to either of the above questions, in what capacity?** ❒ Temporary ❒ Permanent**Is the child home educated?**  ❒ Yes ❒ No Name of Social Worker: …………………………………………………………………………………………Social Worker’s Phone No: ………………..……………………………………………………………………….Name of child’s nursery/school ……………..………………………………………………………………………. |
| **Has the child or family either currently or in the past been known to Children’s Services?**❒ Yes ❒ NoName of Social Worker: …………………………………………………………………………………………Social Worker’s Phone No: ………………..………………………………………………………………………. |
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| **Required Information:** |
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Is your child looking after someone at home? ❒ Yes ❒ No

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| If so, who3? |  |

3  Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

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| What is the adult’s relationship to the child? |  |

Do you think the child would like additional support as a young carer? ❒ Yes ❒ No

Is the child known to services such as Young Carers? ❒ Yes ❒ No

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Is the child being privately fostered (*see definition below*)? ❒ Yes ❒ No

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| --- | --- |
| **If yes,** please provide carer’s name: |  |
| Carer’s relationship to child: |  |
| Contact details of carer: |  |

Are Children’s services aware? ❒ Yes ❒ No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) ([**S.66 Children Act 1989**](http://www.legislation.gov.uk/ukpga/1989/41/section/66))  is placed for 28 days or more in the care of someone who is not the child’s parent(s) or a ‘connected person’. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, **but cannot be a relative**as defined under the [**Children Act 1989, section 105**](http://www.legislation.gov.uk/ukpga/1989/41/section/105):*‘A relative under the Children Act 1989 is defined as a ‘grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent’.*

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| **Please help us trace the child’s previous medical records by providing the following information:** |
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| Your previous address in the UK: | Post Code:  |
|  |  |
| Name of previous Doctor while at that address: |  |
|  |  |
| Surgery Name and Address of previous Doctor: | Post Code:  |
|  |  |
| **If you are from abroad:** |
|  |
| Your first UK address where Registered with a GP: | Post Code:  |
|  |  |
| If previously resident in UK date of leaving: |  | Date you firstcame to the UK: |  |

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| **If registering a child under 5:** |
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❒ I wish the child above to be registered with Heath Hayes Health Centre / Chase Medical Practice for Child Health Surveillance

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| **Child’s Personal Medical History:** |
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| If under 5 years old, type of Birth: *(eg normal, forceps, caesarean)* |  |
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Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year Diagnosed** | **Ongoing** |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |

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| **Family Medical History:** |
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Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Heart Disease** | **Stroke** | **Diabetes** | **High Blood Pressure** | **Asthma** | **Glaucoma** | **Cancer** | **Mental Health Problems** | **Renal/ Kidney** | **Learning Difficulties** |
| **At the time of diagnosis they were:** |
| **Over****60 yrs old** |  |  |  |  |  |  |  |  |  |  |
| **Under** **60 yrs old** |  |  |  |  |  |  |  |  |  |  |

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| **Child’s Immunisations:** |
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Please provide details of your child’s immunisations with dates if possible (under 5’s).

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| **Immunsation** | **Date** | **Immunisation** | **Date** |
| Tetanus |  | Booster: Tetanus |  |
| Whooping Cough |  | Booster: Diphtheria |  |
| Polio |  | Booster: Polio |  |
| HiB |  | Booster: MMR |  |
| Measles |  |  |  |
| MMR |  |  |  |
| BCG (TB) |  |  |  |
| Meningitis |  |  |  |

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| **Child’s List of Current Medication:** |
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| **Name of Medication**  | **Dosage** |
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| **Child’s Allergies:** |
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Please list any allergies the child has to any drugs/medications or if known egg allergy or peanut allergy:

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| --- | --- |
| **Name of Medication**  | **What was the problem or upset?** |
|  |  |
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**Electronic Prescribing Service (EPS)**

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient’s choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. As a practice, we would encourage all patients to opt for electronic prescribing.

 I **DO** give consent for prescriptions to be sent electronically to the pharmacy

 **I DO NOT** give consent for prescriptions to be sent electronically to the pharmacy

Nominated pharmacy……………………………………………………………………………………

Address…………………………………………………………………………………………………….

Postcode………………………………………………………………………………………………….

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| **Child’s Ethnicity:** |
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❒ British or mixed British ❒ Irish ❒ African ❒ Caribbean ❒ Indian ❒ Pakistani

❒ Bangladeshi ❒ Chinese ❒ Other (please state):

❒ Decline to state

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| **Child’s Religion:** |
|  |
| Please state religion of child: |  |

Please advise if you feel your child’s religion will affect any treatment received: ❒ Yes ❒ No

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| **Child’s Language:** |
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| Please state child’s main spoken language: |  |

Does the child need an interpreter? ❒ Yes ❒ No

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| **Data Sharing Consent Choices:** |
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To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for the practice to contact you by the following:

By email ❒ Yes ❒ No This will be to send you letters, the practice newsletter and the like

By text ❒ Yes ❒ No This will be to send you reminders of appointments via text

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| **Signatures:** |
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I confirm that the information that has been provided is true to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

Signature on behalf of patient ❒ Signature of patient ❒

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Person |  | Relationship to Child: |  |

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| --- |
| **Any Additional Information Please Enter In The Box Below:** |

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