Dr Jennifer Rafferty MBChB, DRCOG, MRCGP
Dr Michael Coysh MBChB ,MCEM, MRCGP

CLARENDON SURGERY & THE ANGEL MEDICAL PRACTICE

NEW PATIENT REGISTRATION - CHILD (children under 16)

IF YOUR CHILD IS UNDER THE AGE OF 6 YEARS OLD YOU MUST PROVIDE VACCINATION HISTORY. THE REGISTRATION WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

Please complete as many questions as you can about your child. The information will help the practice to provide better medical care for your family.

Patient Information

Childs Name: ……

Any Previous Surname(s): ……

Gender: Male/Female ……

Place of Birth:…… Date of Birth: ……

Ethnicity: …… Main Language Spoken: ……

Current Nursery / School: ……

Current Address: ……

……

Postcode: ……

Medical History

Does your child have any medical condition?: Yes ☐ No ☐

Please give details: ……

……

……

Clarendon Surgery, Pendleton Gateway, 1 The Broadwalk, Salford M6 5FX
The Angel Medical Practice, The Angel Living Centre, St Phillips Place, Salford M3 5FA
Tel: 0161 983 0190 Email: clarendon.surgery@nhs.net
www.clarendonsurgery.co.uk @clarendonangel Clarendon Surgery & The Angel Medical Practice

Reviewed January 2020

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Does your child have any additional needs or

disabilities?: Yes ☐ No ☐

Please give details: ……

……

Please list any medication that your child is currently taking:

……

……

Please list any medicines, foods, plants or animals to which you think your child is **allergic**:

……

……

Smoking Status: (for 15 years ONLY) …….

If **Yes** Do you wish to discuss stopping smoking? ……Yes……..No…….

Parental/Guardian Details

Parent/Guardian Name: …… Relationship: ……

Tel. No: …… Mobile No: ……

Email Address: ……

Who else lives in your household with your child?

Name	**Age/Date of Birth**	**Relationship to child**

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Do you have parental responsibility for the Child

Yes / No

Is the child you are registering "Looked After" by the local authority or subject of a Child Protection Plan? Yes / No

Does the child/your family have a social worker? Yes / No
Please give name/contact details ……

……

Is your child a carer for you or someone else? Yes / No
Please give details of whom they care for ……

……

For more support check out:
https://www.salford.gov.uk/health-and-social-care/caring-for-someone/young-carers/

Do you know the name of your child's Health Visitor? Yes / No
Please give details ……

……

Is there anything else you think the practice should be aware of? Yes / No

Please give details……

……

Next of Kin

Name: …….. Contact No: ……

Relationship: ……

Summary Care Record Sharing

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Do you object to your child's summary care record being available when you access NHS care outside of your GP Practice (for example NHS Out of Hours Services or Accident & Emergency)? YES/NO

Thank you for your cooperation. If you have any other specific concerns about your child's medical care that you would like us to be aware of, please do book an appointment with the practice.

Name of person completing form: ..... Relationship to child: .....

Today's Date: ..... Signature: .....

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