

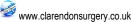
## **NEW PATIENT REGISTRATION - CHILD (children under 16)**

## 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.

ratient 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 $\square$ No $\square$			
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







Does your child have any additional needs or

disabilities?: Yes □ N	lo 🗆			
Please give details:				
Please list any medication t	hat your child is currently:	taking:		
				· • • • • • • • • • • • • • • • • • • •
Please list any medicines, fo				
Smoking Status: (for 15 yea				•••••
		V	N	
If <b>Yes</b> Do you wish to discus	ss stopping smoking?	Yes	No	••
Parental/Guardian Details				
Parent/Guardian Name:		Relationship:		
Tel. No:	M	obile No:		
Email Address:				
Who else lives in your hous	ehold with your child?			
<u>Name</u>	Age/Date of Birth	<u> </u>	Relationship to child	

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## Do you have parental responsibility for the Child

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?  Please give name/contact details	Yes / No
Is your child a carer for you or someone else?  Please give details of whom they care for	Yes / No
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? Please give details	Yes / No
Is there anything else you think the practice should be aware	of? Yes / No
Please give details	
Next of Kin	
Name: Contact N	0:
Relationship:	

Yes / No

## **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:
Todav's Date:	Signature: