**PRE-REGISTRATION FORM (UNDER 18 YEARS OLD)**

**(At least one parent/guardian MUST be registered at the Practice)**

**Your Details**

|  |  |
| --- | --- |
| **Details of person filling out the form:**  **What relationship to you have to the child:**  (example – parent/step parent/guardian/foster carer/social worker) | **First Name:**  **Surname:**  **Address:** |

**CHILDS DETAILS**

|  |  |
| --- | --- |
| **Surname:** | **First Name:** |
| **Date of Birth:** | **Sex : male/female** |
| **Address:**  **Postcode:** | **Contact Details:**  **Home Number:**  **Mobile Number:** |
| **Childs first language:** | **Ethnicity:** |
| **Childs country of birth:** | **If from overseas, when did the child enter the UK:** |

**FAMILY DETAILS**

|  |  |
| --- | --- |
| **Mothers full name:**  **Date of Birth of Mother:** | **Fathers full name:**  **Date of Birth of Father:** |
| **Names and Date of birth of any siblings:** | |
| **Name and relationship to child of any other household members:** | |
| **Address of mother/father\* (if different from child’s address):**  \*delete as appropriate | |
| **Name and address of most recent school or nursery** | |

**HEALTH INFORMATION**

|  |
| --- |
| 1. **Does the child have any major illnesses/ chronic disease or any disabilities?**     Yes 🖵 No 🖵  If so please list below with dates if known: |
| 1. **Does the child take any current or regular medication?**   Yes **🖵** No **🖵**  If so please list below and supply a previous prescription copy as proof |
| 1. **Does the child have any allergies?**   Yes 🖵 No 🖵  If so please list below |
| **IMMUNISATIONS - Please complete the information form below. Also please provide the red book to be photocopied by reception staff.**  **Failure to provide this may prevent registration.** |

**CHILD IMMUNISATIONS**

**AGE DUE** **VACCINE** **DATE GIVEN**

8 weeks old Diphtheria, tetanus, pertussis

(whooping cough), polio,

haemophilus influenza type

B (Hib) & hepatitis B (1st) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumococcal (1st) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Meningococcal group B

(Men B) (1st) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rotavirus Gastroenteritis (1st) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12 weeks old Diphtheria, tetanus, pertussis

Polio, Hib & hepatitis B (2nd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rotavirus (2nd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16 weeks old Diphtheria, tetanus, pertussis

polio, Hib and hepatitis B (3rd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumococcal (2nd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Men B (2nd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 year old (on or Hib and Men C \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

after the child’s

first birthday) Pneumococcal (3rd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Measles, mumps and rubella 1st \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Men B (3rd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 years 4 months Diphtheria, tetanus, pertussis

old or soon after and polio (Booster) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Measles, mumps & rubella 2nd \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name: Date of Birth:**

**FAMILIES RECEIVING ADDITIONAL SUPPORT**

|  |
| --- |
| **Does the child have a social worker?**  Yes 🖵 No 🖵  If yes, please give name, address and contact number: |
| **Is the child in a care home or fostered?**  Yes 🖵 No🖵 |
| **Who Has Parental Responsibility?** |

**Signature of Parent/Guardian/Carer……………………………………………………………..**

**Date………………………………………………….**

This information will be shared with our Child Health Department and members of the Primary Healthcare Team.

If you do NOT want this information to be shared then please tick the box: 🖵