BLACKTHORN HEALTH CENTRE – MEDICAL REGISTRATION (CHILDREN UNDER 16)

Please complete all pages in FULL using BLOCK capitals

Surname:

First Name(s): (in full)

Date of Birth:
(day/month/year)

NHS Number:
(if known)

Telephone Number:

Mobile Number:

Email Address:

Child's School:

Which school does your child attend?

Does your Child have any special educational needs? Yes No

Details:

Personal Medical History / Disabilities:

Type of Birth:
(if under 5)
(eg normal, forceps, Caesarean)

Birth Weight:
(if under 5)

Feeding:
(if under 5)
(Breast or Bottled)

Does your child have any disabilities or have they ever suffered from any important medical illness, operation or admission to hospital that you wish to inform us of? If so please enter the details below:

Condition	Year Diagnosed	Ongoing
		Yes No

		Yes No

Family History:

Have any of your child's close relatives (father, mother, sister, brother only) ever suffered from any of the following: (please indicate who in the boxes)

Heart Attack	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer

Immunisations:

Please provide details of your child's immunisations, with dates if possible (under 5's). In adittion, please give your Red Book to Reception to photocopy.

Immunsation	Year	Immunisation	Year
Tetanus		BCG (TB)	
Whooping Cough		Meningitis	
Polio		Booster: Tetanus	
HiB		Booster: Diphtheria	
Measles		Booster: Polio	
MMR		Other	

Current Medication:

If you have a copy of your child's repeat medications, please pass to Reception to copy.
Please note, you may need to see a Doctor before your prescription(s) are isued.

Name of Medication	Strength	Dosage

Do you have a prefered Pharmacy / Chemist you would like your medication to electronically go to?

Yes
No
(if yes, which Pharmacy / Chemist do you use?)

Allergies:

Please list any allergies your child has to any Drugs / Medication:

Name of Medication	What was the Problem or Upset?

Ethnicity:

Please indicate your child's ethnic origin:

British or mixed British | Irish | African | Caribbean | Indian | Pakistani

Bangladeshi | Chinese | Other (please state): _____

Decline to State

Parent / Guardian / Foster Parent Details:

Name: _____ **Telephone Number**: _____

Relationship to Child: _____

Name: _____ **Telephone Number**: _____

Relationship to Child: _____

Next of Kin:

Name: _____ **Telephone Number**: _____

Relationship to Child: _____

Household Members:

Are there any other Adults in the Household? Yes No

Details: _____

Accessible Information:

Do you have any Information or Communication needs, (such as Hearing Aids) or are you Deaf or Blind?

If yes, please provide as much details as possible:

Do you require an alternative correspondence format?

No **Yes,**
Braille **Yes,**
Large Print **Yes,**
Audio Tape

What is your preferred communication method?

No Preference **Telephone** **SMS Message** **E-Mail Address**
Letter to Home Address
Correspondence to Another Address (Carer or Relative)

Communication Preferences:

Where you have provided information on how to contact you, on behalf of your child, can you confirm you are happy for Blackthorn Health Centre to contact you by the following:

By E-Mail	Yes	No	This will be to send you letters, newsletter, recalls, patient surveys and practice communications
By SMS Text Message	Yes	No	This will NOT opt you out of appointment reminders sent via SMS text messages

Signature:

I confirm that the information I have provided is true to the best of my knowledge.

Signed: **Date**:

Name: **Relationship to Child**: