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

**(At least one parent and/or guardian to be registered at the Practice)**

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| **Details of Person filling in the form:**What relationship do you have to the child(e.g. Parent, Step Parent, Guardian, Foster Carer):  | First Name:Surname:Address: |
| **Child’s Details** |
| Surname: | First Name: |
| Date of Birth : | Sex: Male / Female |
| Address : (if different from above)Post Code :  | Contact details Home Tel.:Mobile No: Preferred Contact Number :SMS Appt. reminders will not be sent to mobile numbers belonging to the parent / guardian of patients between the ages of 13 and 17. |
| Child’s first language: | Ethnicity:Religion: |
| Child’s country of birth: | If from overseas, when did the child enter the country: |
| **Family Details:** |
| Mothers full name:DOB: | Father’s full name:DOB: |
| Names and DOB of siblings: |
| Name and relationship to child of any other household members: |
| Address of mother/father\* (if different from child’s) :\*delete as appropriate |
| Name and address of most recent school or nursery: |
|  |
| **Health Information**  |
| 1. Has the child any major illnesses, operations, chronic illnesses such as Asthma or any disabilities?

Yes 🗌 No 🗌 Please list with dates: |
| 1. Any current or regular medication:

Yes 🗌 No 🗌If “yes” please list below: |
| 1. Is your child allergic to anything?

Yes 🗌 No 🗌If “yes” please list below: |
| 1. Immunisations – Please bring the child’s Red Book
 |
| **Families Receiving Additional Support** |  |
| 1. Does your child have a social worker?

Yes 🗌 No 🗌 (If yes, please give their name, address and contact number) |
| 1. Is the child in a care home or fostered?

Yes 🗌 No 🗌 |
| Who has Parental Responsibility? |

**The Summary Care Record (SCR) is a summary of a patient's allergies and current medication** **uploaded to Spine so that it can be accessed by any legitimate carer, regardless of the computer system they use.**

**The circumstances when this is beneficial include when a patient is seen at a hospital** **or Out of Hours unit or when a temporary resident is seen at a GP practice.**

**Would you like a summary care record yes / no**

**Consent to receive SMS Text Messages yes / no**

**Electronic Prescribing is now available at our surgery. Please nominate your preferred pharmacy :**

**……………………………………………………………………………………………………**

**Please give full name, date of birth, address of any other family members registered with us. Please use another sheet.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **For Office use****ANY CHILD WITH A “YES” TO ANY OF THE QUESTIONS ASKED except allergies NEEDS TO HAVE A ROUTINE APPOINTMENT WITH A DOCTOR BOOKED AT REGISTRATION** |
| **Has the child been offered appointment with doctor?** | Yes 🗌 No 🗌 |
| **If appointment booked please add a comment to the appointment slot stating the reason for the appointment as per the pre reg form.** |  |
| **Red Book Submitted and photocopy to nurse?** | Yes 🗌 No 🗌 |
| **Has the identify and address been checked?****Documents accepted, one only needed.****Tick which one:**Child benefit formNHS card**For those who do not have any of documents above**Passport | Yes 🗌 No 🗌Yes 🗌 No 🗌Yes 🗌 No 🗌Yes 🗌 No 🗌 |
| **Has Parental Responsibility been established?****Documents accepted, one only needed.****Tick which one:**Birth certificateRed book**If neither of the above available or born outside the country:**Passport | Yes 🗌 No 🗌Yes 🗌 No 🗌Yes 🗌 No 🗌Yes 🗌 No 🗌 |
| **Please state who has parental responsibility:** |  |
| **Who checked the form?****Date:** |  |