Do you have any special communication needs? 🞏 Yes 🞏 No

East Shore Partnership

If yes: 🞏 Sign Language 🞏 Large Print 🞏 Other …………………….

**CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)**

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

Previous Surnames

**Title**: 🞏 Mr 🞏 Miss **Gender:** 🞏 Male 🞏 Female 🞏 Indeterminate 🞏 Unknown

Date of Birth (day/month/year) NHS Number 🞏🞏🞏 🞏🞏🞏 🞏🞏🞏🞏

 (if known)

Town & country of Birth

 Post Code:

Address

Telephone number: Mobile number:

Email address:

Parent 1 Name & DOB:

Current GP Surgery if not East Shore Partnership:

Parent 2 Name & DOB:

Current GP Surgery if not East Shore Partnership:



Other adults permanently living at address:

(For safeguarding)

Is the Parent 1 resident at the same address? Yes 🞏 No 🞏

Is the Parent 2 resident at the same address? Yes 🞏 No 🞏

If new born will anyone be bringing them for immunisations other than the parent? Yes 🞏 No 🞏

Name & Relationship to child

**Please help us trace your previous medical records by providing the following information:**

Your previous address in UK

 Post Code:

Name of previous Doctor

while at that address

 Post Code:

Address of previous Doctor

**If you are from abroad:**

Your first UK address where

 Post Code:

Registered with a GP

If previously resident in UK Date you first

date of leaving came to UK

What is your main Spoken Language?

Is English a second language? Yes / No

If any of the following apply please tick:

Asylum Seeker

Unaccompanied Asylum Seeker

Looked after child (Foster)

**Is any member of your immediate family serving in the British Armed Forces:**

Yes, I am a member of a

British military family:

**NHS Organ Donor registration:**

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

🞏 Any of my organs and tissue or

🞏 Kidneys 🞏 Heart 🞏 Liver 🞏 Corneas 🞏 Lungs 🞏 Pancreas 🞏 Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.

For more *information please ask at reception for an information leaflet or visit the website* [*www.uktransplant.org.uk*](http://www.uktransplant.org.uk) *or call 0300 123 23 23*

**NHS Blood Donor registration:**

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years 🞏

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

*For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work)*

……………………..………………………………………………………………… Post code: ………………….

**Personal Medical History…..**

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing**  |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |

**Family History…..**

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart attack | Stroke | Diabetes | High blood pressure | Asthma | Glaucoma | Cancer |
|  |  |  |  |  |  |  |

**Immunisations ……**

Please provide details of your childs immunisations with dates if possible (under 5’s). If possible pelase give your Red Book to Reception to photocopy:

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunsation** | **Date** | **Immunisation** | **Date** |
| Tetanus |  | Booster: Tetanus |  |
| Whooping Cough |  | Booster: Diphtheria |  |
| Polio |  | Booster: Polio |  |
| HiB |  | Booster: MMR |  |
| Measles |  |  |  |
| MMR |  |  |  |
| BCG (TB) |  |  |  |
| Meningitis |  |  |  |

**List of current medication ……**

|  |  |
| --- | --- |
| **Name of medication**  | **Dosage** |
|  |  |
|  |  |

Which Pharmacy would you like to nominate for any prescriptions to be sent to?

|  |  |
| --- | --- |
| **Name of Pharmacy**  | **Address** |
|  |  |

**Allergies ……**

Please list any allergies you have to any drugs/medication:

|  |  |
| --- | --- |
| **Name of medication** | **What was the problem or upset?** |
|  |  |
|  |  |

**Ethnicity ……**

**vej**

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

🞏 Bangladeshi 🞏 Chinese 🞏 Other (please state):

🞏 Decline to state

**Next of kin ……**

**vej**

Name: Tel. contact

 number:

Relationship:

**Data sharing consent choices ……**

**vej**

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read our Privacy Statements available in the practice, or at [www.eastshorepartnership.co.uk](http://www.eastshorepartnership.co.uk)

Where you have provided information on how to contact you, can you confirm you are happy for The East Shore Partnership to contact you by the following:

By email 🞏 Yes 🞏 No e.g. send letters, newsletter etc

By text 🞏 Yes 🞏 No e.g. appointment reminders etc

Proxy online access to your child record 🞏 No e.g. book appointments, view results etc

(age <11 years old)

**Signature ……**

**vej**

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

Signed: Date:

Signature on behalf of patient 🞏 Signature of patient 🞏

For Practice use only:

|  |  |
| --- | --- |
| Identity verified through(tick all that apply) | [ ]  Birth certificate[ ]  Photo ID (if available)[ ]  Proof of residence |
| Name of Verifier |  | Date |  |
| Person registering on SystmOne |  | Date |  |