

**PRE-REGISTRATION FORM (UNDER 18 YEARS OLD)**  
**(At least one parent and/or guardian to be registered at the Practice)**

<b>Details of Person filling in the form:</b>  What relationship do you have to the child (e.g. Parent, Step Parent, Guardian, Foster Carer):	First Name:  Surname:  Address:
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**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:	Father's full name:
DOB:	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:

2. Any current or regular medication:

Yes  No

If "yes" please list below:

3. Is your child allergic to anything?

Yes  No

If "yes" please list below:

4. 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)

2. 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 :

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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.

**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**

<b>Has the child been offered appointment with doctor?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If appointment booked please add a comment to the appointment slot stating the reason for the appointment as per the pre reg form.</b>	
<b>Red Book Submitted and photocopy to nurse?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Has the identify and address been checked? Documents accepted, one only needed. Tick which one:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child benefit form	Yes <input type="checkbox"/> No <input type="checkbox"/>
NHS card	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>For those who do not have any of documents above</b>	
Passport	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Has Parental Responsibility been established? Documents accepted, one only needed. Tick which one:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Birth certificate	Yes <input type="checkbox"/> No <input type="checkbox"/>
Red book	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If neither of the above available or born outside the country:</b>	
Passport	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Please state who has parental responsibility:</b>	
<b>Who checked the form?</b>	
<b>Date:</b>	