## ROWAN TREE PRACTICE

# REGISTRATION FORM (CHILDREN)

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| CHILD PATIENT INFORMATION FORM |
| Patient’s last name:First: Middle: | ❑ Miss | ❑ Master |
| Any Delivery Problems? ❑ Yes ❑ No | Birth date: |  | Sex: |
|  / / |  | ❑ M | ❑ F |
| Was your child premature? ❑ Yes ❑ No |
| Has your child had any developmental checks, if so which ones: |
| Has your child had any diseases or operations? ❑ Yes ❑ No  |
| What were these, when did they occur and did they need to be admitted to Hospital ❑ Yes ❑ NoPlease give details:  |
| Any allergies i.e.: Asthma/ Eczema/Other : ❑ Yes ❑ NoPlease give details:  |
| Any allergic/abnormal reactions to medications or vaccinations: ❑ Yes ❑ NoPlease state: |
| Does your child have any medical problems at present: ❑ Yes ❑ NoPlease state: |
| **CHILD PATIENT INFORMATION FORM** |
| Any disabilities or sensory impairment that you would like us to be aware of? ❑ Yes ❑ No |
| Please State: |
| Is your child currently taking prescribed medications? ❑ Yes ❑ No If YES please list below:  |
| Does your child have any significant family history of illness affecting their brothers, sisters, parents or grandparents: ❑ Yes ❑ No

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| Diabetes ❑  | Asthma ❑  | COPD ❑ |
| Hypertension ❑  | Heart Disease ❑  | Stroke ❑  |
| Epilepsy ❑ | Thyroid Disease ❑ | Cancer ❑ |
| Depression ❑ | Other Mental Illness ❑ | Other ❑ |

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| Children – 14 – 16 YEARS ONLY  |
| Does your child smoke? | NO | YES (approx. how many per day) Please state: |
| Online Patient Access from 16 Years? |  |  |

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| CHILDREN CONTACT IN CASE OF EMERGENCY***IMPORTANT\*\*\* IT IS YOUR RESPONSIBILITY TO INFORM US IF YOUR CONTACT DETAILS CHANGE – ESPECIALLY ADDRESS AND MOBILE TELEPHONE NUMBERS*** |
| Next of Kin:- contact name and details: | Relationship to patient: | Home phone  | Mobile No: |
| Parent  | Guardian | Foster Carer | Other |
| The above information is true and accurate to the best of my knowledge. |
|  |  |  |  |
|  | Patient/Guardian signature |  | Date |

**PLEASE ADD DATES WHEN VACCINATIONS WERE GIVEN:**

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| **CHILD REGISTRATION FORM – PERSONAL IMMUNISATION RECORD** |
| **VACCINATION** | **1st Dose** | **2nd Dose** | **3rd Dose** | **Other** | **Pre-School** | **Booster** | **Given in UK or Elsewhere?****Please state:** |
|  |  |  |  |  |  |  |  |
| **Pertussis** (Whooping Cough)Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Diptheria**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Tetanus**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hib**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Polio**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Pneumococcal**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Men C**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hib MenC**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Rotavirus**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Influenza**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Meningitis B**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **MMR**MeaslesMumps Rubella | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **BCG**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hep A**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hep B**Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **HPV****Date:** | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |