## 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 ❑ No  Please give details: | | | | |
| Any allergies i.e.: Asthma/ Eczema/Other : ❑ Yes ❑ No  Please give details: | | | | |
| Any allergic/abnormal reactions to medications or vaccinations: ❑ Yes ❑ No  Please state: | | | | |
| Does your child have any medical problems at present: ❑ Yes ❑ No  Please 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   |  |  |  | | --- | --- | --- | | 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**  Measles  Mumps  Rubella | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **BCG**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hep A**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hep B**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **HPV**  **Date:** | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |