**REGISTRATION FORM FOR CHILD OR YOUNG PERSON**

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| Today’s Date: | NHS Number if known: | Date of Birth: |
| Surname: | First Name(s): | Male / Female |
| Current Address:Post Code:  | Home Tel:Mobile Tel:Other: |
| First Language Spoken: | Religion: |
| Ethnic Origin: | Place of Birth: |
| Name of School / Nursery: | Has child been known by any other name?YES / NO (If YES, please give details): |
| Name and Address of previous GP: | Previous Address IF from abroad:Date first entered the UK: |

**Details of Child’s Main Carer:**

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| --- | --- |
| Surname: | First Name: |
| Current Address (if different from child’s): | Contact Details (if different from above): |
| What is your relationship to the child? (Mother, Father – please specify): | Consent to be contacted by text message:YES / NO |

**Does the child have contact with? Father YES / NO Mother YES / NO**

|  |  |
| --- | --- |
| Surname: | First Name: |
| Current Address (if different to child’s): | Contact Details (if different from child’s): |
| Is there a: Special Guardianship Order? YES / NO Residence Order? YES / NO Supervision Order? YES / NO  |
| Is the child’s care: PRIVATE / STATE Name of Carer: Are they subject to a Care Order? YES / NO or Interim Care Order? YES / NOAre they subject to an Emergency Protection Order? YES / NORemanded to Local Authority care? YES / NOSubject to a Secure Order? YES / NOName and contact details of lead social worker:Individual(s) who have parental responsibility (in case of consent): |
| Does the child have any disabilities or distinguishing features? YES / NOIf YES, please give details: |
| Please state any significant medical history:Is the child on any repeat medication? YES / NOIf YES, please give details:Does the child suffer from any allergies? YES / NOIf YES, please give details:Is there any significant family history? (e.g. asthma, heart conditions etc.) YES / NOIf YES, please give details: |
| Are you happy to share your records with any health care worker your doctor feels is necessary for your medical care? | YES | NO |
| Are you happy for your child to have a Summary Care Record? | YES | NO |

**HOUSEHOLD COMPOSITION**

**Please list all persons (adults and children) who live at the address with this child**

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| Surname: | First Name:  | Date of Birth: | Occupation/School/Nursery | Relationship to Child e.g. Sibling/Aunt | Registered at Surgery:YES or NO |
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