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 ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth (day/month/year) NHS Number (if known) ☐☐☐ ☐☐☐ ☐☐☐☐

Town & country of Birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

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

Address of previous Doctor

Post Code:

If you are from abroad:

Your first UK address where Registered with a GP

Post Code:

If previously resident in UK date of leaving

Date you first came to UK

If registering a child under 5:

☐ I wish the child above to be registered with [insert name of practice] for Child Health Surveillance

If you need your doctor to dispense medicines & appliances*:

For Dispensing Practices only:

☐ I live more than 1 mile in a straight line from the nearest chemist

Personal Medical History…..

Type of Birth:
(eg normal, forceps, Caesarean If under 5)

Birth Weight:
(If under 5)

Feeding:
(Breast or bottlefed If under 5)

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

Allergies ……

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

Name of medication	What was the problem or upset?

Ethnicity ……

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese ☐ Other (please state): _____
☐ Decline to state

Next of kin ……

Name: _____ Tel. contact number: _____

Relationship: _____

Data sharing consent choices ……

*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 the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.*

*If you wish to **OPT OUT** please complete the form found with this leaflet.*

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, and would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to provide updates on new campaigns at the practice, and the use of text messaging to send patients reminders about the details of their next appointment.

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting us.

For full details on our privacy notice go to the website www.kirklandsurgery.co.uk or full copies are in the practice waiting rooms.

Consent for Kirklands to contact me by email ☐ Yes ☐ No

Consent for Kirklands to contact me by text ☐ Yes ☐ No

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 ☐