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| YSTRADGYNLAIS GROUP PRACTICE |

CHILD REGISTRATION FORM

**Please print clearly Date**

**Surname** **First Name/s**

**Date of Birth** **Home Tel. Number**

**Address** **Postcode**

Mobile Tel Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please confirm if you give consent for us to:

Send SMS text messages Yes / No and emails using the above information. Yes / No

Please see attached information about consent.

**Child’s ethnic group (Please tick one)**

British/Mixed British  Irish  Other White background  White & Black Caribbean

White & Black African  White & Black Asian  Other Mixed Background

Indian/ British Indian  Pakistani/British Pakistani  Bangladeshi/British Bangladeshi

Other Asian background  Caribbean  African  Other Black Background  Chinese

Other ethnic group (please give details)

**Full Name of Parents / Guardians**

Please confirm who has parental responsibility

Joint Mother only Father only Guardian

**Tel. Number of Parent / Guardian (if different)**

**Name and address of current nursery/school**

**Name of previous Health Visitor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Medical History

Does your child suffer from: (please circle)

Asthma Yes / No

Diabetes Yes / No Epilepsy Yes / No

Please provide date of last review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any other operations or illnesses (e.g. tonsils removed etc.?) Yes / No

If yes, (please list below and give dates where possible

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccinations:** Has your child been vaccinated with the following:

|  |  |
| --- | --- |
| **8 Weeks** | **Date and Country vaccination given** |
| **DTaP/IPV/Hib** |  |
| **PCV** |  |
| **Men B** |  |
| **Rotarix** |  |
| **12 Weeks** |  |
| **DTaP/IPV/Hib** |  |
| **Rotarix** |  |
| **16 Weeks** |  |
| **DTaP/IPV/Hib** |  |
| **PCV** |  |
| **Men B** |  |
| **12 Months** |  |
| **Hib/ Men C** |  |
| **MMR** |  |
| **PCV** |  |
| **Men B** |  |
| **3 years and 4 months** |  |
| **MMR** |  |
| **DaP/IPV or dTaP/IPV** |  |
| **Full immunisation record is required at the time of registration** | |

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Family History

Has anyone in your immediate family suffered with: (please circle)

Asthma Yes / No Cancer Yes / No Diabetes Yes / No

Heart Attack Yes / No Stroke Yes / No High Blood Pressure Yes / No

Other

**General Health and Social History** (please circle)

Height Weight

Does our child have any allergies? (E.g. aspirin, penicillin) No / Yes (give details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on any regular medication? No / Yes (give details)

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Patient Consent for Email and Text Message Communication

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. We 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 developments at the practice
* the use of text messaging to send patients reminders about the details of their next appointment
* Provide test results and changes in medication

*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 speaking to a Patient Coordinator.*