

REGISTRATION FORM FOR CHILD OR YOUNG PERSON

ID IS REQUIRED FOR REGISTRATION WHICH CONFIRMS DATE OF BIRTH AND ADDRESS

Date form completed:		NHS Number (if known):					
Details of child/young person being registered							
Forename(s):		Surname:					
Date of Birth :		Sex: Male / Female					
Current Address :		Contact Telephone Numbers					
		Home:					
Post Code :	Mobile:						
First language spoken:		Religion:					
Ethnic origin:		Place of birth:					
Name of School/Nursery:	Has the child/young person been known by any othername :YES /NOIf yes please give details:						
Name and address of previous GP:		Previous address if from abroad:					
		Date first came to UK:					
Details of Child/young person's Ma	in Carer						
First Name:		Surname:					
Current address (if different to child/yo	Contact Telephone Numbers (if different from above)						
		Home:					
	Mobile:						
What is your relationship to the child/y (ie Mother, father - specify)		Consent to be contacted by text message YES/NO					
Does this child/young person live with both parents?		•	YES	1	NO		
Is this child/young person adopted?			YES		NO		
Is this child/young person fostered?			YES	ſ	NO		
Please give details of parent not listed							
First Name:		Surname:					
Current address (if different to child/young person):		Contact Telephone Numbers (if different from above) Home:					
		Mobile:					
What is their relationship to the child/young person : (ie Mother, father - specify)		Does the child/young person have contact with this parent? YES/NO					
PLEASE PROVIDE MEDICAL HISTORY OVERLEAF							
FOR OFFICE USE ONLY:							
FORM OF ID SEEN TO CONFIRM FORM OF DATE OF BIRTH: ADDRESS	' ID SEEN TO CONFF :	KIM FORM	SIGNED:		SEEN BY:		

Any other significant carers involved in the upbringing of this child/young person or young person (eg Stepfather, aunt, grandparent or Foster carer), If yes please give details:									
Are any other services known or involved with family or young person? Eg Social Care, CAMHS: YES / NO If yes, please give details :,									
Does the child/young person have any disabilities or distinguishing features ? YES / NO If yes, please give details:									
Please state any significant medical history :									
Is the patient on any repeat medication? YES / NO If yes please give details: Does the child/young person suffer from any allergies? YES / NO If yes please give details:									
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Is there any significant family history? ie. Asthma/Heart conditions									
Is this child/young person a smoker?: YES / NO Does this child/young person consume alcohol? YES / NO									
Are you aware of the summary care record? YES/NO									
HOUSEHOLD COMPOSITION Please list all persons (adults and children) who live at the address with this child/young person									
First Name	Surname	Date of Birth	Occupation or School or Nursery	Relationship to child/young person ie. Sibling/aunt etc	Registered at surgery (Yes/No)				