|  |
| --- |
| **Please complete all pages in FULL using BLOCK capitals** |
|  |
| **Surname**: |       |
|  |
| **First Name(s)**: (in full) |       |
|  |
| **Previous Surnames**: |       |
|  |
| **Title**: | [ ]  Mr [ ]  Miss |
|  |
| **Gender**: | [ ]  Male [ ]  Female |
|  |
| **Date of Birth**: (day/month/year) |       |
|  |
| **Address**: |       |
|  |
| **Post Code**: |       |
|  |
| **Telephone Number**: |       | **Mobile Number**: |       |
|  |
| **Email Address**: |       |

|  |
| --- |
| **If you Need your Doctor to Dispense Medicines & Appliances:** |
|  |
| [ ]  | My child lives more than 1 mile (1.6km) “as the crow flies”, from the nearest Chemist / Pharmacy and would therefore like the Surgery to dispense their Medicines and Appliances |

|  |
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| **Disabilities / Personal Medical History ……** |
|  |
| **Type of Birth**:*(if under 5)**(eg normal, forceps, Caesarean)* |       |
|  |
| **Birth Weight**:*(if under 5)* |       | **Feeding**:*(if under 5)**(Breast or Bottled)* |       |
|  |
| **Does your child have any disabilities or have they ever suffered from any important medical illness, operation or admission to hospital that you wish to inform us of?****If so please enter the details below**: |
|  |
| **Condition** | **Year Diagnosed** | **Ongoing** |
|       |       | [ ]  Yes [ ]  No |
|       |       | [ ]  Yes [ ]  No |

|  |
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| **Family History ……** |
|  |
| **Have any of your child’s close relatives (father, mother, sister, brother only) ever suffered from any of the following**: (please indicate who in the boxes) |
|  |
| **Heart Attack** | **Stroke** | **Diabetes** | **High Blood Pressure** | **Asthma** | **Glaucoma** | **Cancer** |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
| **Immunisations ……** |
|  |
| **Please provide details of your child’s immunisations with dates if possible (under 5’s).****If possible please give your Red Book to Reception to photocopy.** |
|  |
| **Immunsation** | **Year** | **Immunisation** | **Year** |
| Tetanus |       | Booster: Tetanus |       |
| Whooping Cough |       | Booster: Diphtheria |       |
| Polio |       | Booster: Polio |       |
| HiB |       | Booster: MMR |       |
| Measles |       |  |
| MMR |       |
| BCG (TB) |       |
| Meningitis |       |

|  |
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| **Allergies ……** |
|  |
| **Please list any allergies your child has to any Drugs / Medication**: |
|  |
| **Name of Medication** | **What was the Problem or Upset?** |
|       |       |
|       |       |
|       |       |
|       |       |

|  |
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| **Current Medication ……** |
|  |
| If you have a copy of your child’s repeat medications, please pass to Reception to copy |
|  |
| **Name of Medication** | **Strength** | **Dosage** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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| --- |
| **Ethnicity ……** |
|  |
| **Please indicate your child’s ethnic origin**: |
|  |
| [ ]  British or mixed British | [ ]  Irish | [ ]  African | [ ]  Caribbean | [ ]  Indian | [ ]  Pakistani |
|  |
| [ ]  Bangladeshi | [ ]  Chinese | [ ]  Other (please state): |       |
|  |
| [ ]  Decline to State |
| **Parent / Guardian / Foster Parent Details ……** |
|  |
| **Name**: |       | **Telephone Number**: |       |
|  |
| **Relationship to Child**: |       |
|  |
| **Name**: |       | **Telephone Number**: |       |
|  |
| **Relationship to Child**: |       |

|  |
| --- |
| **Next of Kin ……** |
|  |
| **Name**: |       | **Telephone Number**: |       |
|  |
| **Relationship to Child**: |       |

|  |
| --- |
| **Household Members ……** |
|  |
| **Are there any other Adults in the Household?** | [ ]  Yes [ ]  No |
|  |
| **Details**: |       |

|  |
| --- |
| **Child School ……** |
|  |
| **Which school does your child attend?** |       |
|  |
| **Does your Child have any special educational needs?** | [ ]  Yes [ ]  No |
|  |
| **Details**: |       |

|  |
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| **Communication Preferences ……** |
|  |
| **Where you have provided information on how to contact you, on behalf of your child, can you confirm you are happy for Bishops Waltham Surgery to contact you by the following**: |
|  |
| By E-Mail | [ ]  Yes [ ]  No | This will be to send you letters, newsletter, recalls and the like |
|  |
| By SMS Text Message | [ ]  Yes [ ]  No | This will NOT opt you out of appointment reminders sent via sms text messages |

|  |
| --- |
| **Signature ……** |
|  |
| **I confirm that the information I have provided is true to the best of my knowledge.** |
|  |
| **Signed**: |  | **Date**: |       |
|  |
| **Name**: |       | **Relationship to Child**: |       |