STOCKWELL GROUP PRACTICE NEW BABY & CHILD Aged 6 YEARS AND UNDER

FIRST NAME:			
SURNAME:			
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)

Please list anyone else that lives at the same address as the child stating relationship, include siblings and other adults.	
EMAIL ADDRESS:	

WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad, child etc.)	**MOBILE:**	**Mother [ ] Father [ ] Other…………………**
	EMAIL:	**Mother [ ] Father [ ] Other…………………**
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?	**HOME:**	**YES** ☐ **NO** ☐ (please tick)
	MOBILE:	**YES** ☐ **NO** ☐ (please tick)
NEXT OF KIN: (Name and Tel No.	**Mother………………………………………………….. Father………………………………………………….. Other …………………………………………………..**	

Ethnicity …… Please indicate your child's ethnic origin: : *Please tick one box*

White	Asian or British Asian	Mixed Race	Black or Black British	Chinese or other ethnic Group
☐ *British* ☐ *Traveller* ☐ *Other White (please state*	☐ *Indian* ☐ *Pakistani* ☐ *Bangladeshi* ☐ *Other Asian (please State):*	☐ *White & Caribbean* ☐ *White & African* ☐ *White & Asian* ☐ *Other Mixed (please State):*	☐ *Caribbean* ☐ *African* ☐ *Other Black (Please state)*	☐ *Chinese* ☐ *Other Ethnicity (please state):*

☐ Decline to state (Please note that some illness are more prevalent in some ethnic groups e.g. Sickle Cell

MEDICATION

IS YOUR CHILD ON ANY REGULAR MEDICATION?	**YES** ☐ **NO** ☐ (please tick)

If Yes, please state name and dose <u>or provide a printout</u> from a previous GP if available
(Please note they will be required to see the doctor for a first repeat prescription to be issued by this practice)

IS YOUR CHILD ALLERGIC TO ANY MEDICATION/FOOD?	**YES** ☐ **NO** ☐ (please tick)

If Yes, please state type and name:

MEDICAL HISTORY		
Please give details of any medical condition eg Asthma or Diabetes illnesses, accidents, hospital admissions, investigations or operations your child has had :		
		Date:

FAMILY HISTORY		**Please specify relation eg parent/grandparent or sibling**
Cancer	**YES** ☐ **NO** ☐	
Stroke	**YES** ☐ **NO** ☐	
Heart Disease	**YES** ☐ **NO** ☐	
Diabetes	**YES** ☐ **NO** ☐	

Please provide us with the information about your child immunisations that they have received. You MUST bring along any records you have in your **RED Child Health Book** (vaccination history/book) when you come to the Practice. Any immunisation from outside the UK should also be provided.
Immunisation records are very important for the wellbeing of your child. Collecting this information will ensure that we have an up to date record, including when the next vaccinations are due.

Who is the main carer, e.g.: parent/guardian……………………..………………………………………

Name of current school/nursery…………………………………………………………………………

Social Services involvement – YES [ ]   NO [ ]

If yes, please give name of Social Services/Social Worker …………………………………………………

Summary Care Record
You have a choice of what information you share. Only Authorised healthcare staff can view your **SCR** with your permission. The information shared will be solely for the benefit of your care. Please indicate your choice below. More information is available on https://digital.nhs.uk/services/summary-care-records-scr or you can talk to your GP practice or call NHS Digital on 0300 303 5678

Express consent to share Medication, Allergies and Adverse Reactions only **[ ]** Read code **9Ndm**

Express consent to share Medication, Allergies and Adverse Reactions and **Additional Information**
e.g. Illnesses and health problems, vaccination you have had [ ] Read code **9Ndn**

Express DISSENT (<u>**OPT OUT**</u>) – select this if you **DO NOT** want to share information with other healthcare professionals
[ ] Read code **9Ndo**

Please sign ………………………………………….. **Print Name**…………………………………………………

Date ………………/……………../…………

In order to be fully registered with this practice, this form MUST be completed and signed by the parent/guardian

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Staff Use only: **Asked to provide Imms record [ ]**
ID checked- (please tick) Birth certificate [ ] Passport [ ]

Other please state ………………………………………………………………………

Staff initials ………………… Date Rec……/………/……. entered on EMIS ……../……./……