Reading Walk-In Health Centre
SRCCG.readingwalkinhealthcentre@nhs.net

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

Registering a New Birth; the practice would like to congratulate you on your recent bundle of joy and would like to guide you in that it will require the Full Birth Certificate and Red Book in order to get baby Registered.

NEW BABY & CHILD QUESTIONNAIRE (FOR 0 TO 16 YEAR OLDS)			
TITLE:		**FIRST NAME:**	
SURNAME:			
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)
ADDRESS (incl flat no):		**WHO ELSE LIVES IN THIS HOUSEHOLD?**	
		IS YOUR CHILD THE LONE OR PARTIAL CARER FOR SOMEONE? If yes, please specify:	**YES** ☐ **NO** ☐ (please tick)
HOME TEL:		**MOBILE TEL:**	
EMAIL ADDRESS:			
MOTHER NAME AND DOB			
MOTHERS DETAILS	**MOBILE:**		
	EMAIL:		
FATHERS NAME AND DOB			
FATHERS DEATILS	**MOBILE:**		
	EMAIL:		
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?	**HOME:**	**YES** ☐ **NO** ☐ (please tick)	
	MOBILE:	**YES** ☐ **NO** ☐ (please tick)	
NEXT OF KIN: (Name, Address, Tel No.)			

Ethnicity ……

Please indicate your ethnic origin:

☐ White British ☐ White Irish ☐ White Other

☐ Bangladeshi ☐ Black African ☐ Black Caribbean ☐ Pakistani

☐ Mixed White Asian ☐ Mixed White/Caribbean ☐ Mixed White/Black African ☐ Chinese

☐ Other Mixed ☐ Other Black ☐ Other Asian ☐ Other Ethnic Group

Other (please state): _____

Decline to state: _____

What is your first spoken language? _____

Do you need an interpreter? Yes / No

MEDICATION	
IS YOUR CHILD ON ANY REGULAR MEDICATION?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state name and dose: (Please note they will be required to see the doctor for a first repeat prescription to be issued)	
IS YOUR CHILD ALLERGIC TO ANY DRUGS/MEDICATION/FOOD?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state type and name:	

MEDICAL HISTORY

HAS YOUR CHILD HAD/STILL HAVE ANY OF THE FOLLOWING (please tick) **:**

High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations your child has had :

	Date:
	Date:
	Date:
	Date:

FAMILY HISTORY

Has a first degree relative of your child (parent or sibling) suffered from any of the following conditions? (please tick)

Cancer	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Stroke	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Heart Disease	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Diabetes	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	

Do any other illnesses run in your family? YES ☐ **NO** ☐

If Yes, Please give details:

All Parents/Guardian to Complete, Continued

Vaccinations

If your child is 0-5 Yrs kindly provide us with the information about your child immunisations 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.

Age Due	Vaccine	Tick if Given	Date Given	At GP Surgery	Other
Birth Onward	**BCG, Hepatitis B course of 4 injection at birth,1,2 and 6mths**				
2 months	**1st 6-in-1 Vaccine, 1st Pneumococcal, 1st Rotavirus, 1st Men B**				
3months	**2nd 6-in-1 Vaccine, 2nd Rotavirus**				
4months	**3rd 6-in-1 Vaccine, 2nd Pneumococcal, 2nd Men B**				
12 months	**1st MMR, 3rd Pneumococcal, 3rd Men B, Hib/Men C,**				
2-6 years	**Children's flu vaccine (annual)**				
3yrs 4 Months	**4-in-1 pre-school booster, 2nd MMR**				
12-13 years girls only	**1st HPV Vaccine 2nd HPV Vaccine**				
14 years	**MEN ACWY**				

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.

In line with the Government's new Child Protection procedures, we are now required to ask for specific information on all new patients registering with us under the age of 16 years.
We would very much appreciate your help in this matter, and any information you provide will be regarded as confidential.

1. Who is the main carer, e.g.: parent/guardian……
2. Name of current school……
3. Social Services involvement – YES/NO……
4. If yes, please give name of Social Services/Social Worker……

   ……

By submitting this registration form, you indicate your consent to opting-in for these services. If you do not want to receive the service use the opt-out forms indicated and return it to reception.

Data sharing consent choices ……..

1. NHS England has introduced the **Summary Care Record (SCR**), which will be used in emergency care. The record will only contain information about any medicines you are taking, allergies from which you suffer and any adverse reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely. Your Summary Care Record will be available to authorised healthcare professionals providing your care anywhere in England, but they will, where possible, ask your permission before they look at it. This means that if you have an accident or become ill, those treating you can have immediate access to important information about your health.

If you wish to **OPT OUT** please complete a SCR Opt-Out form from reception

2. Your mobile number and email address may be used by the Surgery to contact you for the following reasons:

Text - to send you reminders for appointments, vaccinations, annual reviews, surgery closures etc.

Email - to send you personal letters, surgery newsletters and occasional questionnaires.

If you wish to **OPT OUT** please complete a Text/Email Opt-Out form from reception

I confirm that the information I have provided is true to the best of my knowledge.

Signature:……

Date:

Signature of parent ☐ Signature of guardian ☐

Checklist before coming in to the surgery;

1. **Have you completed all relevant sections?**
2. **Have you signed all relevant sections?**
3. **Have you completed the GMS1 registration form?**
4. **Do you have 2 different forms of identification and a copy or your passport?**