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**CHILDREN (UNDER 16 YEARS OLD)**

**Confidential New Patient Registration Questionnaire**

|  |  |
| --- | --- |
| **Surname:** | **First Name(s):** |
| **Date Of Birth:** | **Gender:** Male Female |
| **Address:** | **Home Telephone:** |
| **Mobile Telephone:** |
| **Consent to receive text messages via mobile re. child:** Yes No | |
| **Place Of Birth:** | **NHS Number:** |
| **Emergency Contact Name and Number:** | **Previous GP Details (*GP Name, Practice Name & Practice Address*):** |
| **Parent(s) Carer Name:** |
| **School/Nursery Name:** | **School/Nursery Address:** |

**Please indicate your ethnicity**

British or mixed British

Irish

Other White background

White & Black African

White & Asian

Other Mixed background

Indian or British Indian

Pakistani or British Pakistani

Bangladeshi or British Bangladeshi

Other Asian background

Caribbean

African

Other Black background

Chinese

Other

Ethnic category not stated, *please state ethnicity……………………………………………………..*

**What is your first language?..............................................................................................................**

**CHILD’S MEDICAL HISTORY**

**Has your child had any of the following illnesses:**

|  |  |  |
| --- | --- | --- |
| Measles | German Measles | Whooping Cough |
| Asthma | Chickenpox |  |
| Mumps | Fits |  |

**Has your child had any hospital admissions for serious illnesses or accidents?**

Yes

No

**Is there a history of fits/epilepsy in child’s parents/brothers/sisters?**

**…………………………………………………………………………………………………………………………………………..**

**…………………………………………………………………………………………………………………………………………..**

* **Due to Child Protection guidelines, children will not be registered without a parent/legal guardian also being registered at the practice.**
* **A birth certificate may be asked for to confirm who has parental responsibility for a child.**

**Please confirm name/s of person/s with parental responsibility for registering child:**

**…………………………………………………………………………………………………………………………………………..**

**Do you consent for another adult (grandparent, au pair) to seek medical advice/treatment for your child?**

Yes

No

**If yes, please provide the names of persons to whom this consent applies and relationship to child**

**…………………………………………………………………………………………………………………………………………..**

**SIGNATURE OF PARENT/LEGAL GUARDIAN: ………………………………………………………………………………..**

**NAME OF PARENT/LEGAL GUARDIAN: ………………………………………………………………………………………..**

**DATE: …………………………………………………………………………………………………………………………………**

**WE REQUIRE AN UP TO DATE IMMUNISATION HISTORY OF CHILDREN UP TO THE AGE OF 5 UPON REGISTRATION**

**PLEASE BRING YOUR RED BOOK TO THE SURGERY**