Clift Surgery

Please bring the child's Red Book with you so we can take a copy of their immunisation record.

CONFIDENTIAL MEDICAL REGISTRATION FORM (Children Under 16) Child's Personal Details:

Please complete all pages i	n FULL usi	ng BLO	CK capita	ls		
Child's Surname:						
Child's First Names (in full):						
Previous Surnames:						
Title:	☐ Master	J Miss	☐ Ms	☐ Male	☐ Female	
Date of Birth (day/month/year):				NHS Number: (if known)		
Town & Country of Birth:						
Address:						
	Post Code): 				
Telephone Number:				Mobile Numb	per ¹ :	
			Text	¹ Note, we use to messages will automatically o		r for text messages. Child is 11 vears old.
Email Address ² :				, , ,		
² Please specify whose above email addre	ess this is, e.g.pa	arent, guard	ian etc.			
Name of Parent(s) / Carers				ental Responsibility	2 Nex	t of Kin?
1.		☐ Yes	yai / i ui v		Yes	□ No
2.		☐ Yes		□ No	☐ Yes	□ No
If not the above, name of plegal responsibility:	erson with					
Contact details of person responsibility	with legal					
Does the child have any sp	ecial comn		on / mobi	lity needs? Yes	. □ No	
If yes: ☐ Wheelchair ☐ Wall			earing Aid	lity needs? □ res □ Large Print		
		<u> </u>	_	•		
☐ Lip Reading☐ Braille ☐ British Sign Language ☐ Makaton Sign Language ☐ Other:						
Is the child currently:				fugee 🗖 An Asylum	n Seeker	
Is the child a child in care?		☐ Yes	□ No			
Is the child a "Looked After Child"?			☐ Yes	□ No		
If yes to either of the above	questions	, in what	t capacity	? □ Temporary	☐ Permane	ent
Is the child home educated	?		☐ Yes	□ No		
Name of Social Worker:						
Social Worker's Phone No:						
Name of child's nursery/scho	ol					

Has the child or family eith	er currently or in the past been know	wn to Children's Services?
☐ Yes ☐ No		
Name of Social Worker:		
Social Worker's Phone No:		
Required Information:		
Is your child looking after sor	meone at home?	□ Yes□ No
If so, who ³ ? ³ Please tell us if thechild is looking after	r someone who is ill, frail, disabled, has mental healtl	n/emotional support needs or substance misuse problems
What is the adult's relationship to the child?		
Do you think the child would	like additional support as a young care	er? □ Yes□ No
Is the child known to services	s such as Young Carers?	☐ Yes☐ No
Is the child being privately for	stered (see definition below)?	□ Yes□ No
If yes, please provide carer's Carer's relationship to child: Contact details of carer:	name:	
Are Children's services awa	re?	☐ Yes☐ No
days or more in the care of someone e.g. a cousin or a great aunt, but canr	who is not the child's parent(s) or a 'connected pers	has a disability) (<u>S.66 Children Act 1989</u>) is placed for 28 on'. Private foster carers can be from the extended family, <u>1989, section 105</u> : 'A relative under the Children Act 1989 or by marriage or civil partnership) or step-parent'.
Please help us trace the ch	ild's previous medical records by pr	roviding the following information:
Your previous address in the UK:		
	Post Code:	
Name of previous Doctor while at that address:		
Surgery Name and Address of previous Doctor:		
	Post Code:	
If you are from abroad:		
Your first UK address where Registered with a GP:		
	Post Code:	
If previously resident in UK date of leaving:		te you first to the UK:
If registering a child under	5:	

☐I wish the child above to be registered with Clift Surgery for Child Health Surveillance										
If you need your doctor to dispense medicines and appliances*:										
For Dispensing Practices only:										
☐I live more than 1 mile in a straight line from the nearest chemist										
Patient Declaration for all patients who are not ordinarily resident in the UK:										
Please see appendix 1 for patient declaration (last page of form)										
Child's Personal Medical History:										
If under 5 y (eg normal,										
•			•	•		llness, oper se use box			o hospita	ll? If so
Condition	1					Year	Diagno	sed	Ongoing	
									Y	es/No
									Y	es/No
									Y	es/No
Family M	edical His	story:								
Have any	close rela	tives (fat	ther, moth	er, sister, b	rother o	nly) ever suf	fered fro	m: (please in	dicate who	in the boxes)
	Heart	Ctualca		High						
	Disease	Stroke	Diabetes	Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal/ Kidney	Learning Difficulties
At the time				Blood	Asthma	Glaucoma	Cancer	Health		_
At the time Over 60 yrs old Under 60 yrs old				Blood	Asthma	Glaucoma	Cancer	Health		_
Over 60 yrs old Under	of diagnos	sis they w		Blood	Asthma	Glaucoma	Cancer	Health		_
Over 60 yrs old Under 60 yrs old Child's In	of diagnos	ions:	ere:	Blood Pressure				Health Problems	Kidney	_
Over 60 yrs old Under 60 yrs old Child's In	nmunisat ovide deta Book to F	ions:	ere:	Blood Pressure	ons with			Health Problems	Kidney	Difficulties
Over 60 yrs old Under 60 yrs old Child's In Please pr your Red	nmunisat ovide deta Book to F	ions:	ere: our child's in to photoe	Blood Pressure	ons with	dates if pos		Health Problems	Kidney	Difficulties
Over 60 yrs old Under 60 yrs old Child's In Please pr your Red Immunsa Tetanus Whooping	nmunisat ovide deta Book to F	ions:	ere: our child's in to photoe	Blood Pressure	ons with Immu Booste Booste	dates if pos	sible (un	Health Problems	Kidney	Difficulties
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Over 60 yrs old Under 60 yrs old Child's In Please pr your Red Immunsa Tetanus Whooping Polio HiB Measles MMR BCG (TB)	nmunisat ovide deta Book to F tion	ions:	ere: our child's in to photoe	Blood Pressure	ons with Immu Booste Booste Booste	dates if pos nisation er: Tetanus er: Diphther er: Polio	sible (un	Health Problems	Kidney	Difficulties
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Over 60 yrs old Under 60 yrs old Child's In Please pr your Red Immunsa Tetanus Whooping Polio HiB Measles MMR BCG (TB) Meningitis	nmunisat ovide deta Book to F tion	cions: ails of your Reception rent Mee	ere: our child's in to photoe Da	Blood Pressure	ons with Immu Booste Booste Booste	dates if pos nisation er: Tetanus er: Diphther er: Polio	sible (un	Health Problems	Kidney	Difficulties
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Child's Allergies:	
Please list any allergies the child has to any dru	igs/medications or if known egg allergy or peanut allergy:
Name of Medication	What was the problem or upset?
Child's Ethnicity:	
□British or mixed British □Irish □Africal □Bangladeshi □Chinese □ □Decline to state	n □Caribbean □Indian □Pakistani □Other (please state):
Child's Religion:	
Please state religion of child:	
Please advise if you feel your child's religion will	l affect any treatment received: ☐ Yes☐ No
Child's Language:	
Please state child's main spoken language:	
·	□ Yes□ No
Data Sharing Consent Choices:	
healthcare organisations (eg Emergency Depart what part of your record is extracted and how it is lift you wish to OPT OUT please complete the for Where you have provided information on how to of practice] to contact you by the following: By email Yes No This will be	rm found with this leaflet. contact you, can you confirm you are happy for [insert name to send you letters, the practice newsletter and the like to send you reminders of appointments via text
Signed:	Date:
Signature on behalf of patient	atient
Name of Person	Relationship to Child:
Box for extra details:	

Updated 26/09/17 Appendix 1

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK							
Patient's Details	Please complete in BLOCK CAPITALS and tick ✓as appropriate						
☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Ms Surname:						
Date of Birth	First Names:						
NHS No.	Previous Surname/s:						
☐ Male ☐ Female Town and Country of Birth:							
Home Address:							
Postcode:	Telepho	one No:					
Anybody in England can register with a GP practice and receive free medical care from that practice. However if you are not ordinarily resident: in the UK you may have to pay for NHS treatment outside of the GP practice, Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'Indefinite leave to remain' in the UK. Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges. More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Micrant patient leaflet, available from your GP practice. You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment, regardless of advance payment. The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitab) and NHS Digital, for the purposes of validation, invoiding and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided. Please tick one of the following boxes: a) I understand that I may need to pay for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested () I do not know my chargeable status. I dedare that the Information I give on this form is correct and complete. I understand that If it is not correct, appropriate action may be taken against me. A parent/guardian should complete the form on behalf of a child under 16.							
Print name: On hehalf of:		Relationship to patient:					
Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK. NON-UK FUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS							
If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))(S1, you may be billed	YES: NO: SOUTH NO: NO.	PRC balow:					
for the cost of any treatment received outside of the GP practice, including at a nospital. PRC validity period (a) From:	8: Identification number of the card 9: Expiry Date DO MM YYYY	(b) To					
Please tick if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff. How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process. Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.							