LEICESTER TERRACE HEALTH CARE CENTRE

CHILD NEW PATIENT REGISTRATION FORM

Welcome to Leicester Terrace Health Care Centre. Please complete all sections below.

PERSONAL DETAILS			
Child's Surname:	Child's Forename:		Child's DOB:
Address:		Postcode:	Male ☐ Female ☐
Tel Home: Preferred number ☐	Tel Mobile: Preferred number ☐	May we send you text messages to your phone concerning your child's health care? Mobile ☐ Home ☐	
Email address: May we contact you by email and/or send correspondence by email? Yes ☐ No ☐			

PARENT/GUARDIAN DETAILS	
Parent/Guardians Title and Full Name: Do you hold parental responsibility? Yes ☐ No ☐	Relationship to Child: DOB:
Parent/Guardians Address:	
Parent/Guardians Title and Full Name: Do you hold parental responsibility? Yes ☐ No ☐	Relationship to Child: DOB:
Parent/Guardians Address:	

HEALTH DETAILS
Please list any allergies:
Has your child ever been involved with a Children's Social Service Team? Yes ☐ No ☐ Do you have a current Social Worker? Yes ☐ No ☐ If yes, please state name:
Please state any serious illnesses, operations, accidents or disabilities:
Please state any family history of serious illness or inherited disease:

Please list regular medications below and book an appointment with a Doctor when your child's registration is complete to discuss their medications:

OTHER INFORMATION	
Nationality:	Main Spoken Language:

Ethnic Group – please circle:

British or Mixed British / English / Irish / Polish / White & Black African / Chinese / White & Asian / Caribbean/White & Black Caribbean / African Indian or British Indian / Pakistani or British Pakistani / Bangladeshi or British Bangladeshi

Other Black, Asian, White or Mixed Background (Please state)

Does your child have an existing **Summary Care Record**?	Would you like to opt out of the Summary Care Record?	Would you like more time to decide?
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Would you like to nominate your chosen pharmacy so that your prescriptions can be sent through electronically?

If so, please state the pharmacy of your choice:

IF YOU WOULD LIKE YOUR CHILD TO HAVE A HEALTH CHECK PLEASE BOOK AT RECEPTION

For Surgery use only. All information checked by:

Reviewed Feb 2023

Child Health Record
New Patient registration details

PLEASE WRITE CLEARLY AND IN BLOCK LETTERS (ONE FORM PER CHILD)

CHILD'S CURRENT DETAILS		**CHILD'S PREVIOUS DETAILS**	
Surname:		Surname:	
Forename(s):		Forename(s):	
NHS No:	D.O.B:		
Current Address: Temp/permanent (delete as applicable)		Previous Address: Temp/permanent (delete as applicable)	
Post code:	Tel.No.	Postcode:	
GP Practice: Name: Address:	Name of School:	GP Practice: Name: Address:	Name of School:

PARENT/CARER DETAILS			
Surname	Forename(s)	Date of birth	Relationship to child

Please turn over and complete Immunisation details

Immunisation record

Routine Childhood Immunisations (Delete any not given)	Age usually given	Date Given			Please indicate if Declined with reason
1st Diphtheria, tetanus, pertussis, polio, Hib and Hepatitis B	2 months				
Meningitis B					
Rotarix					
2nd Diphtheria, tetanus, pertussis, polio, Hib and Hep B	3 months				
Pneumococcal					
Rotarix					
3rd Diphtheria, tetanus, pertussis, polio, Hib and Hepatitis B	4 months				
Meningitis B					
Hib/ Men C (Menitorix)	12 months				
1st MMR (Measles, Mumps, Rubella)					
Pneumococcal (PCV) booster					
Meningitis B					
2nd MMR	3 years 4 months approx.				
4th Diphtheria, tetanus, pertussis, polio (Pre School Booster)					
Human Papillomavirus vaccine (HPV)	Females only 12 -18 years	1st	2nd	3rd	
5th Diphtheria, tetanus, pertussis, polio (School leavers booster)	13 – 18 years				
Meningitis ACWY					

NON ROUTINE VACCINES	Date given				
Mantoux test	Result:				
BCG					
Meningitis C					
Hib Booster (Haemophilias Influenza B)					
Hepatitis B	1st	2nd	3rd	4th	5th

Other Vaccines received /Other Information.