

Child registration - Health questionnaire

Personal details

Name of child being registered

Child's date of birth (DD/MM/YYYY)

Does the child have any siblings and are they registering with the practice?

Yes No

Details of the person completing registration on behalf of the child

Name (Title, First name, Surname)

Address (if different from child's)

Contact number

Email address

Relationship to child

Mother Father Other (please state)

Please tick to confirm that you have legal responsibility for the child

Emergency contact details (mother, father, legal guardian)

Name

Relationship to child

Mother Father Other (please state)

Contact number

Permissions

We will need to contact you for example to discuss any results or to invite you to appointments, please let us know how you would like us to contact you.

If you are registering a child under five, please confirm that you wish to register the child with Practice Plus for Child Health Surveillance.

Yes No

Can we contact you by text?

Yes No

Can we leave a message on your voicemail if we call?

Yes No

Can we leave a message with a third party if we call (e.g. family or household member)?

Yes No

Can we email you with information about the practice, health campaigns, patient newsletters etc.?

Yes No

Do you require any support with communication?

Yes No

If you need support with translation/interpretation, please state in which language you require this

Do we have your permission to hold a summary care record for you*?

Yes No

*The summary care record is an electronic summary of your most important information, such as any long term condition you have and the medicines you are on. It is created from your GP medical records and can be seen and used by authorised staff in other areas of the health care system, for example out-of-hours doctors, or hospital doctors to ensure they are able to give you the best and most appropriate care.

Child's health profile

Height

Weight

Does the child you are registering have any allergies? Yes No

If yes, please provide details

Does the child you are registering have any ongoing health problems? (Please tick as applicable)

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes type 1 | <input type="checkbox"/> Diabetes type 2 | <input type="checkbox"/> Repeat infections |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Mental health problems | <input type="checkbox"/> Atrial fibrillation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HF | <input type="checkbox"/> CHD |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Stroke | | |

We would like to offer your child a health and lifestyle check (if you don't require an appointment). Please tick if you would like us to arrange an appointment with you. Yes No

Does the child you're registering have a disability? Yes No

If yes, please provide details

Is the child you are registering taking any prescribed medications? Yes No

If yes, please provide details

Would you like to use the Electronic Prescription Service? (This allows you to choose a pharmacy for your child's electronic prescriptions to be sent to) Yes No

If yes, please provide the name and address of your chosen pharmacy

If your child has an ongoing health problem, a disability or is currently taking a regular medication we need to book an appointment for them so that we can ensure that their care continues and to enable us to continue prescribing their regular medications. We will call you to book an appointment.

Family history – have the child's parents or siblings had any of the following (please tick)

- | | | | |
|---|---|-----------------------------------|--|
| <input type="checkbox"/> Bowel cancer | <input type="checkbox"/> Prostrate cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Other cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Mental health | <input type="checkbox"/> CVD | <input type="checkbox"/> High blood pressure |

If the child is aged 4 or over, please provide the name and address of their school.

Is the child subject to a child protection plan? Yes No

Is the child in foster care? Foster care Private foster Neither

Accessibility

N.B. These questions are about yourself and not the child you are registering.

To ensure the services we provide are accessible to all, please answer the following questions.

I am happy to answer questions about myself.

Yes No

If yes, please answer the questions below:

What is your ethnic background?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> English/Welsh/Scottish/N Irish | <input type="checkbox"/> Irish | <input type="checkbox"/> Any other white background | <input type="checkbox"/> African |
| <input type="checkbox"/> Caribbean | <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Black African | <input type="checkbox"/> Bangladeshi |
| <input type="checkbox"/> White and Asian | <input type="checkbox"/> Any other Black/African/Caribbean background | | <input type="checkbox"/> Arab |
| <input type="checkbox"/> Indian | <input type="checkbox"/> Any other Mixed/Multiple ethnic background | | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Pakistani | <input type="checkbox"/> Any other ethnicity | <input type="checkbox"/> Any other Asian background | <input type="checkbox"/> Rather not say |

What is your religion?

- | | | | |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Agnostic | <input type="checkbox"/> Atheist | <input type="checkbox"/> Buddhist | <input type="checkbox"/> Christian |
| <input type="checkbox"/> Hindu | <input type="checkbox"/> Church of England | <input type="checkbox"/> Islam | <input type="checkbox"/> Jewish |
| <input type="checkbox"/> Jehovah's Witness | <input type="checkbox"/> Pagan | <input type="checkbox"/> Rather not say | |

Further information

If there is any further information you feel it would be useful for us to know please provide it below.

Thank you for completing this form. Please ensure it is handed into your local Practice Plus surgery along with your GMS1 registration form.