

**Parent/Guardian Details**

Title		Surname	
Date of Birth		First names	
Occupation		Previous surnames	

Home Address
Postcode

Home Tel	
Mobile	
Email	

By giving us your mobile phone number and your e-mail address you consent to us contacting you by either of these methods.

**Child's Details**

Surname		Date of Birth:	
First Names		Relationship:	

**Ethnic Group**

White	British <input type="radio"/> / Irish <input type="radio"/> / Other :
Black	Caribbean <input type="radio"/> / African <input type="radio"/> / Other :
Asian	Indian <input type="radio"/> / Pakistani <input type="radio"/> / Chinese <input type="radio"/> / Other :
Mixed	White & Black Caribbean <input type="radio"/> / White & Black African <input type="radio"/> / White & Asian <input type="radio"/> / Other : Information Refused <input type="radio"/>

What is your child's first language?	
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**Proof of Identity and Address Provided?**

Birth Certificate <input type="radio"/>	Passport <input type="radio"/>	Utility Bill <input type="radio"/>	Other:
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**Medical Information**

Please list any serious illnesses/operations/accidents/disabilities and the year they took place:

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Has your child suffered from? (tick as appropriate)

Epilepsy <input type="radio"/>	Diabetes <input type="radio"/>
Cancer <input type="radio"/>	Depression <input type="radio"/>
Eczema/Hay Fever <input type="radio"/>	Asthma <input type="radio"/>

Please list any medicines being taken and the amount:

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Is your child registered disabled? (If yes, please give details) Yes  No

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Is your child allergic to any medicines and if so, which? Yes  No

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**Other Information**

<b>Smoking (if appropriate)</b>	
Does your child smoke?	Yes <input type="radio"/> No <input type="radio"/>
If "No", have they ever smoked? Yes <input type="radio"/> No <input type="radio"/> If Yes Date stopped:	
If they currently smoke, how many cigarettes or ounces of tobacco do they smoke per week?	
Would they like advice on giving up smoking?	Yes <input type="radio"/> No <input type="radio"/>

**Family History**

<b>Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease:</b>

This Practice actively supports Child Protection Policies in Northamptonshire which requires us to record whether this child has ever had a Social Worker involved with your family? <b>YES/NO</b>
Please provide the name of the school/nursery attended

Signature	Date

Please tick to register for on-line ordering of repeat medication and appointment booking

**SUMMARY CARE RECORD**

This record contains information about any medicines your child is taking, allergies they suffer from and any bad reactions to medicines they have. Their Summary Care Record will be available to authorised healthcare staff providing their care in England, but they will ask your permission before they look at it.

We need to record your wishes with regards to the Summary Care Record, therefore please indicate below:

Q1: Does your child an existing Summary Care Record?	YES or NO
Q2: If No do you wish us to create a Summary Care Record for you?	YES or NO
Q3: If No to Q2 Would you like more time to make a decision?	YES or NO

Our Receptionists have more information about the Summary Care Record should you want.

**ENHANCED DATA SHARING**

We use a secure electronic records computer system called SystemOne. With your permission, it allows clinicians to share information held on your child's medical record with other health care professionals to provide the best possible care for them.

Q1: Do you wish the information held here to be shared with other health care professionals?	YES or NO
Q2: Do you wish the information recorded about you by other healthcare professionals (this includes any future care services you may visit) to be shared with this Surgery	YES or NO

For practice use only

ID seen: Yes No

Address Confirmed: Yes No