**REGISTRATION FORM FOR CHILD OR YOUNG PERSON**

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| --- | --- | --- | --- |
| Today’s Date: | NHS Number if known: | | Date of Birth: |
| Surname: | First Name(s): | | Male / Female |
| Current Address:  Post Code: | | Home Tel:  Mobile Tel:  Other: | |
| First Language Spoken: | | Religion: | |
| Ethnic Origin: | | Place of Birth: | |
| Name of School / Nursery: | | Has child been known by any other name?  YES / NO (If YES, please give details): | |
| Name and Address of previous GP: | | Previous Address IF from abroad:  Date first entered the UK: | |

**Details of Child’s Main Carer:**

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| --- | --- |
| Surname: | First Name: |
| Current Address (if different from child’s): | Contact Details (if different from above): |
| What is your relationship to the child? (Mother, Father – please specify): | Consent to be contacted by text message:  YES / NO |

**Does the child have contact with? Father YES / NO Mother YES / NO**

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| --- | --- | --- | --- |
| Surname: | First Name: | | |
| Current Address (if different to child’s): | Contact Details (if different from child’s): | | |
| Is there a: Special Guardianship Order? YES / NO  Residence Order? YES / NO  Supervision Order? YES / NO | | | |
| Is the child’s care: PRIVATE / STATE Name of Carer:  Are they subject to a Care Order? YES / NO or Interim Care Order? YES / NO  Are they subject to an Emergency Protection Order? YES / NO  Remanded to Local Authority care? YES / NO  Subject to a Secure Order? YES / NO  Name and contact details of lead social worker:  Individual(s) who have parental responsibility (in case of consent): | | | |
| Does the child have any disabilities or distinguishing features? YES / NO  If YES, please give details: | | | |
| Please state any significant medical history:  Is the child on any repeat medication? YES / NO  If YES, please give details:  Does the child suffer from any allergies? YES / NO  If YES, please give details:  Is there any significant family history? (e.g. asthma, heart conditions etc.) YES / NO  If YES, please give details: | | | |
| Are you happy to share your records with any health care worker your doctor feels is necessary for your medical care? | | YES | NO |
| Are you happy for your child to have a Summary Care Record? | | YES | NO |

**HOUSEHOLD COMPOSITION**

**Please list all persons (adults and children) who live at the address with this child**

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| Surname: | First Name: | Date of Birth: | Occupation/School/  Nursery | Relationship to Child e.g. Sibling/Aunt | Registered at Surgery:  YES or NO |
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