## **REGISTRATION FORM FOR CHILD OR YOUNG PERSON**

| Surgery Details: Market Square Surgery     | Date form completed:                             |
|--|--|
| Waltham Abbey Health Centre                |  |
| 13 Sewardstone Road, Waltham Abbey, Essex, | NHS Number if known:                             |
| EN9 1NP                                    |  |
| Details of child being registered          |  |
| Surname:                                   | Forename(s):                                     |
| Date of Birth :                            | Sex: Male / Female                               |
| Current Address :                          | Contact details                                  |
|  | Home Tel.:                                       |
|  | Mobile No:                                       |
|  |  |
| Post Code :                                |  |
| First language spoken:                     | Religion:  |
| Ethnic origin:                             | Place of birth:                                  |
| Name of School/Nursery                     | Has the 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 came to UK:                           |

## Details of Childs Main Carer:

| Surname:  | First Name:                                    |
|---|--|
| Current address (if different from child's):                          | Contact details (if different from above):     |
| What is your relationship to the child: (ie Mother, father - specify) | Consent to be contacted by text message Yes/No |

## Does the child have contact with the father : YES / NO

| Surname:                                   | First Name:                             |
|--|---|
| Current address (if different to child's): | Contact details (if different to child) |

## PLEASE FAX THIS PAGE TO THE CHILD HEALTH DEPT. FAX: **01279 698810.** BOTH PAGES TO BE SCANNED.

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|--|-------------------------|------------|------------------|-------------------------|---------------------------|--------------------------|--|
| Childs Surname:  |                         |            | Childs Forename: |                         |                           |                          |  |
| Any other significa<br>grandparent or Fos<br>If yes please give de   | ter carer)              | he upbrii  | nging o          | f this child or young p | erson (eg Stepfathe       | r, aunt,                 |  |
| Are any other servi  | ices known or involve   | d with fa  | mily or          | young person? Eg Soo    | cial Care, CAMHS:         | YES / NO                 |  |
| If yes, please give d  | etails :                |            |                  |                         |                           |                          |  |
|  |                         |            |                  |                         |                           |                          |  |
| Does the child have<br>If yes, please give d   | •                       | ory loss ( | or com           | munication needs? YI    | ES / NO                   |                          |  |
|  |                         |            |                  |                         |                           |                          |  |
|  |                         |            |                  |                         |                           |                          |  |
| Please state any sig   | gnificant medical histo | ory :      |                  |                         |                           |                          |  |
|  |                         |            |                  |                         |                           |                          |  |
| Is the patient on any repeat medication? YES / NO<br>If yes please give details:                               |                         |            |                  |                         |                           |                          |  |
| <b>Does the child suffer from any allergies</b> ? YES / NO<br>If yes please give details:                      |                         |            |                  |                         |                           |                          |  |
| Is there any significant family history? ie. Asthma/Heart conditions   |                         |            |                  |                         |                           |                          |  |
| Is the child or YP a smoker?: YES / NO Does the child consume alcohol? YES / NO                                |                         |            |                  |                         |                           |                          |  |
|  |                         |            |                  |                         |                           |                          |  |
| HOUSEHOLD COMPOSITION<br>Please list all persons (adults and children) who live at the address with this child |                         |            |                  |                         |                           |                          |  |
| Surname  | First Name              | DOB        |                  | Occupation/School       | Relationship to child ie. | Registered<br>at surgery |  |

| Surname | First Name | DOB | Occupation/School<br>/<br>Nursery | Relationship to<br>child ie.<br>Sibling/aunt etc | Registered<br>at surgery<br>(Yes/No) |
|---------|------------|-----|-----------------------------------|--|--------------------------------------|
|         |            |     |                                   |  |                                      |
|         |            |     |                                   |  |                                      |
|         |            |     |                                   |  |                                      |
|         |            |     |                                   |  |                                      |
|         |            |     |                                   |  |                                      |
|         |            |     |                                   |  |                                      |