CONFIDENTIAL MEDICAL REGISTRATION FORM (Children Under 16)

Child's Personal Details:

Please complete all pages in FULL using BLOCK capitals

Child's Surname:

Child's First Names (in full):

Previous Surnames:

Title: ❒ Master ❒ Miss ❒ Ms ❒ Male ❒ Female

Date of Birth (day/month/year): | | | | | | | | NHS Number: (if known) | | | | | | | | | | |

Town & Country of Birth:

Address:

Post Code:

Telephone Number: Mobile Number[1]:

[1] Note, we use the mobile number for text messages. Text messages will automatically cease when the Child is 11 years old.

Email Address[2]:

[2] Please specify whose above email address this is, e.g. parent, guardian etc.

Name of Parent(s) / Carers	Has Legal / Parental Responsibility?		Next of Kin?	
1.	❒ Yes	❒ No	❒ Yes	❒ No
2.	❒ Yes	❒ No	❒ Yes	❒ No
If not the above, name of person with legal responsibility:				
Contact details of person with legal responsibility				

Does the child have any special communication / mobility needs? ❒ Yes ❒ No

If yes: ❒ Wheelchair ❒ Walking Aid ❒ Hearing Aid ❒ Large Print

❒ Lip Reading ❒ Braille ❒ British Sign Language

❒ Makaton Sign Language ❒ Other: ……..

Is the child currently: ❒ A Refugee ❒ An Asylum Seeker

Is the child a child in care? ❒ Yes ❒ No

Is the child a "Looked After Child"? ❒ Yes ❒ No

If yes to either of the above questions, in what capacity? ❒ Temporary ❒ Permanent

Is the child home educated? ❒ Yes ❒ No

Name of Social Worker: ……

Social Worker's Phone No: ……

Name of child's nursery/school ……

Has the child or family either currently or in the past been known to Children's Services?

❒ Yes ❒ No

Name of Social Worker: ……

Social Worker's Phone No: ……

Required Information:

Is your child looking after someone at home? ❒ Yes ❒ No

If so, who[3]?

[3] Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

What is the adult's relationship to the child?

Do you think the child would like additional support as a young carer? ❒ Yes ❒ No

Is the child known to services such as Young Carers? ❒ Yes ❒ No

Is the child being privately fostered (*see definition below*)? ❒ Yes ❒ No

If yes, please provide carer's name:

Carer's relationship to child:

Contact details of carer:

Are Children's services aware? ❒ Yes ❒ No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) (**S.66 Children Act 1989**) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person'. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, **but cannot be a relative** as defined under the **Children Act 1989, section 105**:*'A relative under the Children Act 1989 is defined as a 'grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent'.*

Please help us trace the child's previous medical records by providing the following information:

Your previous address in the UK:

Post Code:

Name of previous Doctor while at that address:

Surgery Name and Address of previous Doctor:

Post Code:

If you are from abroad:

Your first UK address where Registered with a GP:

Post Code:

If previously resident in UK date of leaving:

Date you first came to the UK:

If registering a child under 5:

❒ I wish the child above to be registered with The Cambridge Practice for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*:

For Dispensing Practices only:

❒ I live more than 1 mile in a straight line from the nearest chemist

Patient Declaration for all patients who are not ordinarily resident in the UK:

Please see appendix 1 for patient declaration (last page of form)

Child's Personal Medical History:

If under 5 years old, type of Birth:
(eg normal, forceps, caesarean)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

Condition	Year Diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family Medical History:

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

	Heart Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal/ Kidney	Learning Difficulties
At the time of diagnosis they were:										
Over 60 yrs old										
Under 60 yrs old										

Child's Immunisations:

Please provide details of your child's immunisations with dates if possible (under 5's). If possible please give your Red Book to Reception to photocopy:

Immunsation	Date	Immunisation	Date
Tetanus		BCG (TB)	
Whooping Cough		Meningitus	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles		Booster:Tetanus	
MMR		Booster: Diphtheria	

Child's List of Current Medication:

Name of Medication	Dosage

Child's Allergies:

Please list any allergies the child has to any drugs/medications or if known egg allergy or peanut allergy:

Name of Medication	What was the problem or upset?

Child's Ethnicity:

❒ British or mixed British ❒ Irish ❒ African ❒ Caribbean ❒ Indian ❒ Pakistani
❒ Bangladeshi ❒ Chinese ❒ Other (please state): _____
❒ Decline to state

Child's Religion:

Please state religion of child: _____

Please advise if you feel your child's religion will affect any treatment received: ❒ Yes ❒ No

Child's Language:

Please state child's main spoken language: _____

Does the child need an interpreter? ❒ Yes ❒ No

Data Sharing Consent Choices:

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for [insert name of practice] to contact you by the following:

By email ❒ Yes ❒ No This will be to send you letters, the practice newsletter and the like
By text ❒ Yes ❒ No This will be to send you reminders of appointments via text

Signatures:

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: Date:

Signature on behalf of patient ❒ Signature of patient ❒

Name of Person Relationship to Child:

Summary Care Records :

Summary Care Records	*Tick (only ONE) as Applicable*
1. Yes I would like a Summary Care Record created containing my medications, allergies and adverse reactions or sensitivities to medications. This summary record will be held on an NHS Central Database and may be used in an emergency when your GP surgery is closed.	
2. Yes I would like a Summary Care Record with medication, allergies and adverse reactions ***PLUS additional important information held on my GP record (e.g. Diagnoses – Asthma (lung disease), kidney disease, renal disease, diabetes, epilepsy, cancer etc. and end of life care requests)*** AND/OR I will come and see my GP to discuss any additional information I would like added to my Summary care Record as soon as possible.	
3. No I do not want a Summary Care Record Please be aware that if you choose not to have a Summary Care Record healthcare staff may not have access to important information about you in an emergency but be assured that you will be cared for to the best of their ability.	

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Patient's Details

Please complete in BLOCK CAPITALS and tick ✓as appropriate

❒ Mr ❒ Mrs ❒ Miss ❒ Ms

Surname:

Date of Birth

First Names:

NHS No.

Previous Surname/s:

❒ Male ❒ Female

Town and Country of Birth:

Home Address:

Postcode:

Telephone No:

SUPPLEMENTARY QUESTIONS

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to patient:**	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	**YES:** ☐ **NO:** ☐	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.