YSTRADGYNLAIS GROUP PRACTICE

CHILD REGISTRATION FORM

Please print clearly **Date** _____________

Surname ___________________________ **First Name/s**_______________________

Date of Birth __________________**Home Tel. Number** ________________________

Address ____

____**Postcode** _______________

Mobile Tel Number ____

E-mail address____

Please confirm if you give consent for us to:

Send SMS text messages Yes / No and emails using the above information. Yes / No

Please see attached information about consent.

Child's ethnic group (Please tick one)

British/Mixed British ☐ Irish ☐ Other White background ☐ White & Black Caribbean ☐

White & Black African ☐ White & Black Asian ☐ Other Mixed Background ☐

Indian/ British Indian ☐ Pakistani/British Pakistani ☐ Bangladeshi/British Bangladeshi ☐

Other Asian background ☐ Caribbean ☐ African ☐ Other Black Background ☐ Chinese ☐

Other ethnic group (please give details) ____

Full Name of Parents / Guardians ____

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Please confirm who has parental responsibility

Joint Mother only Father only Guardian

Tel. Number of Parent / Guardian (if different)_________________________

Name and address of current nursery/school ________________________________

Name of previous Health Visitor: ____

Medical History

Does your child suffer from: (please circle)

Asthma Yes / No

Diabetes Yes / No Epilepsy Yes / No

Please provide date of last review: ______________________________________

Has your child had any other operations or illnesses (e.g. tonsils removed etc.?) Yes / No

If yes, (please list below and give dates where possible

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Vaccinations: Has your child been vaccinated with the following:

8 Weeks	**Date and Country vaccination given**
DTaP/IPV/Hib	
PCV	
Men B	
Rotarix	
12 Weeks	
DTaP/IPV/Hib	
Rotarix	
16 Weeks	
DTaP/IPV/Hib	
PCV	
Men B	
12 Months	
Hib/ Men C	
MMR	
PCV	
Men B	
3 years and 4 months	
MMR	
DaP/IPV or dTaP/IPV	
Full immunisation record is required at the time of registration	

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Family History

Has anyone in your immediate family suffered with: (please circle)

Asthma Yes / No Cancer Yes / No Diabetes Yes / No

Heart Attack Yes / No Stroke Yes / No High Blood Pressure Yes / No

Other ____

General Health and Social History (please circle)

Height ____________________ Weight ____________________

Does our child have any allergies? (E.g. aspirin, penicillin) No / Yes (give details)

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Is your child on any regular medication? No / Yes (give details)

1. ________________________ 2. ______________________ 3. ______________________

Patient Consent for Email and Text Message Communication

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us. We would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to:

- provide updates on new developments at the practice
- the use of text messaging to send patients reminders about the details of their next appointment
- Provide test results and changes in medication

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by speaking to a Patient Coordinator.