The James Cochrane Practice

NHS

Your Child's details (Additional Details for Under 16's)

FIRST NAME(S):		SURNAME:	
MOTHER'S NAME:		FATHER'S NAME:	
ADDRESS: POSTCODE:		WHO LIVES IN THIS HOUSEHOLD? (please tick those that apply) Mum ☐ Dad ☐ Step parent ☐ Partner's parent ☐ Grandparents ☐ Brothers and sisters ☐ How many? ☐ Foster carer ☐ Guardian ☐ Others – Please state:	
DATE OF BIRTH:		GENDER:	M ☐ F ☐ (please tick)
HOME TEL:		MOBILE TEL:	
EMAIL ADDRESS:			
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THIS NUMBER?		MOBILE:	YES ☐ NO ☐ (please tick)
		HOME:	YES ☐ NO ☐ (please tick)
WOULD YOU LIKE TO REGISTER WITH THE PRACTICE FOR SMS TEXT MESSAGE REMINDERS?			YES ☐ NO ☐ (please tick)
WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD? Please tell us their name, contact details and their relationship to the child.			

WHAT IS YOUR CHILD'S FIRST LANGUAGE?
WHAT SCHOOL OR NURSERY DOES YOUR CHILD ATTEND?

DOES YOUR CHILD HAVE CONTACT WITH THE FOLLOWING: (IF SO PLEASE WRITE THEIR NAMES)

A hospital specialist ☐ _____ A health visitor ☐ _____

A social worker ☐ _____ Any other health professionals ☐ _____

HAS YOUR CHILD EVER BEEN UNDER A CHILD PROTECTION PLAN?	YES ☐ NO ☐

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS? If yes, what was this and when?	YES ☐ NO ☐ (please tick)
DOES YOUR CHILD HAVE A DISABILITY OR CHRONIC CONDITION? If yes, please detail below	YES ☐ NO ☐ (please tick)

MEDICATION	
IS YOUR CHILD ON ANY REGULAR MEDICATION? If yes, please tell us the name and dose: If you have a list from your previous GP please give us a copy	YES ☐ NO ☐ (please tick)
(please note you may need to see the doctor for a first repeat prescription to be issued)	
IS YOUR CHILD ALLERGIC TO ANY MEDICATION? If yes, please state type and name:	YES ☐ NO ☐ (please tick)

It is important that your child's immunisations are kept up to date. A current photocopy of the immunisation history will help us to maintain their immunisation record; we can take a photocopy of this at reception. If this is not available then please list below.

IMMUNISATIONS	DATE GIVEN
1st Diptheria, Tetanus, Whooping Cough, Polio, Hib, rotavirus* age 2m	
2nd Diptheria, Tetanus, Whooping Cough, Polio, Hib, rotavirus* age 3m	
3rd Diptheria, Tetanus, Whooping Cough, Polio, Hib age 4m	
1st Pneumococcal age 2m	
2nd Pneumococcal age 4m	
1st Meningitis C age 3m	
Hib / Meningitis C -1st Measles, Mumps, Rubella (MMR) - Booster Pneumococcal age 12-13m	
Booster Diptheria, Tetanus, Whooping Cough, Polio age 3y 4m Booster Measles, Mumps, Rubella (MMR)	
Details of any other immunisations:	

IMPORTANT:

All the information given to the Practice as part of this form will be treated as Confidential. However, to give your child the very best health care we work closely with the Health Visiting and School Nursing Service.

It is therefore our normal Practice to share details of all children registering with the Practice with our NHS colleagues in Health Visiting and School Nursing. If you would prefer that we DO NOT do this could you tick here ☐