chelseaname

**New Patient Registration Form (Children: under 16s)**

**Instructions for completing this form**

1. Complete a separate form for each family member to be registered Date …………………………

2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **1** | **Is your child currently?** | Homeless | | A Refugee | | An Asylum Seeker |
| **Is your child housebound?** | | Yes  No | | Comments: | |

|  |  |
| --- | --- |
| **Please state all countries your child has lived in or visited for periods of greater than 6 months:** | |
| **Country:** | **Dates/Year (If known):** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **2** | **Which vaccinations has your child had?** | | | | |
| **Age** | **Immunisation** | **Date**  **(DD/MM/YY)** | **GP Surgery** | **Private** | **Abroad** |
| **8 weeks** | 1st Diphtheria, Tetanus, Pertussis |  |  |  |  |
| 1st Polio |  |  |  |  |
| 1st HIB |  |  |  |  |
| 1st Rotavirus |  |  |  |  |
|  | 1st Meningitis B |  |  |  |  |
| **12 weeks** | 2nd Diphtheria, Tetanus, Pertussis |  |  |  |  |
| 2nd Polio |  |  |  |  |
| 2nd HIB |  |  |  |  |
| 2nd Rotavirus |  |  |  |  |
| 1st Pneumococcal Vaccine |  |  |  |  |
| **16 weeks** | 3rd Diphtheria, Tetanus, Pertussis |  |  |  |  |
| 3rd Polio |  |  |  |  |
| 3rd HIB |  |  |  |  |
| 2nd Meningitis B |  |  |  |  |
| **12 months** | Hib/Men C Booster |  |  |  |  |
| 3rd Meningitis B |  |  |  |  |
| MMR (Measles, Mumps, Rubella) |  |  |  |  |
| 2nd Pneumococcal Vaccine |  |  |  |  |
| **3 years 4 months old or soon after** | MMR Booster (Measles, Mumps, Rubella) |  |  |  |  |
| Pre-School Booster Diphtheria, Tetanus,  Pertussis & Polio |  |  |  |  |
| **12-13 years old** | HPV vaccine |  |  |  |  |
| **14 Years +** | Booster Diphtheria, Tetanus & Polio |  |  |  |  |
| Meningitis ACWY |  |  |  |  |

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| --- | --- |
| **3** | **Sharing your child’s medical record** |
| **Medical Record Sharing** allows your child’s complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your child’s shared medical record.  **If you don’t want to share your child’s GP record tick here:** |
|  |
| **The Care.data Programme** Collates information about your child and the care they receive. It links information from all the different places where your child receives care, such as their GP, hospital and community services, to help them provide a full picture of your child’s medical needs and the care they are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.  **I wish to OPT OUT from my child’s Personal Confidential Data being shared outside their *GP practice*:**  **I wish to OPT OUT from my child’s Personal Confidential Data being shared with *third parties*:** |
| **National Data Optout**  NHS Digital have created a new opt-out system named the National Data Opt-Out which allows individuals to opt-out of their information being used for planning and research purposes. From 2020 all health and care organisations will have to ensure the opt-out is respected. Individuals who previously opted out with a ‘Type 2’ objection will not have to do anything as you will be automatically be opted out.  If you wish to apply the National Opt-Out, please go to NHS Digitals website here https://www.nhs.uk/your-nhs-data-matters/ |

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| **4** | **Required Information** | |
| Name of parent/s: | 1.  2. |
| Name of person with legal parental responsibility: |  |
| Name of school attended: |  |

|  |  |  |
| --- | --- | --- |
| **5** | **Parent / Guardian permission given** | |
| Permission given for someone other than a Parent/Guardian to accompany your child to an appointment? | |
| Name of person/s:  Relationship: | Parent / Guardian Signature: |

|  |  |  |
| --- | --- | --- |
| **6** | **Signature** | |
| Parent/Guardian signature: | Date: |

|  |  |  |
| --- | --- | --- |
| **CHECKLIST** | | |
| Thank you for completing this form. Please check you have completed all sections where possible.  Please ensure that you bring the following with you to the surgery to complete your registration: | | |
| **1.** | **Completed & Signed New Patient Registration Questionnaire & Practice Agreement** (this form!) |  |
| **2.** | **Completed & Signed PRF1 form** |  |
| **3.** | **Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card |  |
| **4.** | **Proof of Address** – Must be in your name and dated within the past 3 months |  |
|  | One of the following: Utility Bill (Gas, Electricity, Water), Council Tax or Tenancy Agreement |  |
| **5.** | If possible, your **Immunisation Records** – usually the Personal Child Health Record (“Red Book”) |  |
| **6.** | If possible, your **NHS Card** – usually shows your previous GP and your NHS Number |  |
| **7.** | If relevant, your **Repeat Medication Request Slip** from your previous GP |  |

**Please book a New Patient appointment if you are on any regular medication**

**or have any chronic or significant medical condition.**

**Please request a copy of the Practice Leaflet if you have not already received it.**

**Alternatively you can also find more information at our practice website**