**The Oaks Family Practice**

**New Patient Registration Form for Children <18**

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| **Child’s Name** |       |
| **Gender** |       |
| **Date Of Birth** |       |
| **Place of birth** |       |
| **Ethnicity**  |       |
| **Main Language Spoken** |       |
| **Current School/Nursery** |       |
| **Current Address** |       |
| **Previous Address** |       |

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|  | ***YES/NO*** |
| Does the child have any medical conditions?***Please state if yes*** |       |
| Does the child have any additional needs?***Please state if yes*** |       |
| Do you consider your child to have a disability?***Please state if yes*** |       |
| Does the child take ay regular medication?***Please state if yes*** |       |
| Does the child have any allergies?***Please state if yes*** |       |

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| **Who else lives in the household with the child?** |
| Name | Age/Date of Birth | Relationship to child |
|       |       |       |

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|  | ***YES/NO*** |
| Do you have parental responsibility for the child? |       |
| Is the child you are registering ‘looked after’ by the local authority or subject of a child protection plan? |       |
| Is the child a carer for you or someone else?***Please state who if yes*** |      For more support check out: [http://www.bolton.gov.uk/website/pages/young carers.aspx](http://www.bolton.gov.uk/website/pages/young%20carers.aspx) |
| Do you know the name of the child’s health visitor/school nurse?***Please state who if yes*** |       |
| Is there anything else you think the practice needs to be aware of? |       |
| Does the child/your family have a social worker?***Please state who if yes*** |       |

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| **Name of person completing this form** |       |
| **Relationship to the child** |       |
| **Signature** |       |
| **Date** |       |