Practice Plus

NHS

Child registration - Health questionnaire

This is an official document of Practice Plus.

Child registration - Health questionnaire

Personal details

Name of child being registered	
Child's date of birth (DD/MM/YYYY)	
Does the child have any siblings and are they registering with the practice?	Yes ☐ No ☐
Details of the person completing registration on behalf of the child	
Name (Title, First name, Surname)	
Address (if different from child's)	
Contact number	
Email address	
Relationship to child	Mother ☐ Father ☐ Other (please state)
Please tick to confirm that you have legal responsibility for the child	☐
Emergency contact details (mother, father, legal guardian)	
Name	
Relationship to child	Mother ☐ Father ☐ Other (please state)
Contact number	

Permissions

We will need to contact you for example to discuss any results or to invite you to appointments, please let us know how you would like us to contact you.

If you are registering a child under five, please confirm that you wish to register the child with Practice Plus for Child Health Surveillance. Yes ☐ No ☐

Can we contact you by text?	Yes ☐ No ☐
Can we leave a message on your voicemail if we call?	Yes ☐ No ☐
Can we leave a message with a third party if we call (e.g. family or household member)?	Yes ☐ No ☐
Can we email you with information about the practice, health campaigns, patient newsletters etc.?	Yes ☐ No ☐
Do you require any support with communication?	Yes ☐ No ☐
If you need support with translation/interpretation, please state in which language you require this	
Do we have your permission to hold a summary care record for you*?	Yes ☐ No ☐

*The summary care record is an electronic summary of your most important information, such as any long term condition you have and the medicines you are on. It is created from your GP medical records and can be seen and used by authorised staff in other areas of the health care system, for example out-of-hours doctors, or hospital doctors to ensure they are able to give you the best and most appropriate care.

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Child's health profile

Height

Weight

Does the child you are registering have any allergies? Yes ☐ No ☐

If yes, please provide details

Does the child you are registering have any ongoing health problems? (Please tick as applicable)

- ☐ COPD
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Repeat infections
- ☐ Anxiety
- ☐ Depression
- ☐ Mental health problems
- ☐ Atrial fibrillation
- ☐ Asthma
- ☐ Epilepsy
- ☐ HF
- ☐ CHD
- ☐ Hypertension
- ☐ Chronic kidney disease
- ☐ Thyroid problem
- ☐ Cancer
- ☐ HIV
- ☐ Stroke

We would like to offer your child a health and lifestyle check (if you don't require an appointment). Please tick if you would like us to arrange an appointment with you. Yes ☐ No ☐

Does the child you're registering have a disability? Yes ☐ No ☐

If yes, please provide details

Is the child you are registering taking any prescribed medications? Yes ☐ No ☐

If yes, please provide details

Would you like to use the Electronic Prescription Service? (This allows you to choose a pharmacy for your child's electronic prescriptions to be sent to) Yes ☐ No ☐

If yes, please provide the name and address of your chosen pharmacy

If your child has an ongoing health problem, a disability or is currently taking a regular medication we need to book an appointment for them so that we can ensure that their care continues and to enable us to continue prescribing their regular medications. We will call you to book an appointment.

Family history – have the child's parents or siblings had any of the following (please tick)

- ☐ Bowel cancer
- ☐ Prostrate cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ Breast cancer
- ☐ Other cancer
- ☐ Epilepsy
- ☐ Asthma
- ☐ Ovarian cancer
- ☐ Mental health
- ☐ CVD
- ☐ High blood pressure

If the child is aged 4 or over, please provide the name and address of their school.

Is the child subject to a child protection plan? Yes ☐ No ☐

Is the child in foster care? Foster care ☐ Private foster ☐ Neither ☐

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Accessibilty

N.B. These questions are about yourself and not the child you are registering.

To ensure the services we provide are accessible to all, please answer the following questions.

I am happy to answer questions about myself. Yes ☐ No ☐

If yes, please answer the questions below:

What is your ethnic background?

- ☐ English/Welsh/Scottish/N Irish
- ☐ Irish
- ☐ Any other white background
- ☐ African
- ☐ Caribbean
- ☐ White and Black Carribean
- ☐ White and Black African
- ☐ Bangladeshi
- ☐ White and Asian
- ☐ Any other Black/African/Caribbean background
- ☐ Arab
- ☐ Indian
- ☐ Any other Mixed/Multiple ethnic background
- ☐ Chinese
- ☐ Pakistani
- ☐ Any other ethnicity
- ☐ Any other Asian background
- ☐ Rather not say

What is your religion?

- ☐ Agnostic
- ☐ Atheist
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Church of England
- ☐ Islam
- ☐ Jewish
- ☐ Jehovah's Witness
- ☐ Pagan
- ☐ Rather not say

Further information

If there is any further information you feel it would be useful for us to know please provide it below.

Thank you for completing this form. Please ensure it is handed into your local Practice Plus surgery along with your GMS1 registration form.