SUMMERCROFT SURGERY

Childrens Application

Title: ..... **First Name:** ..... **Surname:** .....

Middle Name (S): ..... **Date of Birth:** .....

NHS Number: ..... **Gender:** ☐ **Male** ☐ **Female**

School: .....

Is your main language English? ☐ **Yes** ☐ **No** **If no, please state main language:** .....

Do you require an interpreter? ☐ **Yes** ☐ **No**

Ethnicity:

☐ British or mixed British	☐ Irish	☐ Other White background	
☐ White and Black Caribbean	☐ White and Black African	☐ White and Asian	☐ Other mixed background
☐ Indian or British Indian	☐ Pakistani or British Pakistani	☐ Bangladeshi or British Bangladeshi	☐ Other Asian background
☐ Caribbean	☐ African	☐ Other Black background	
☐ Chinese	☐ Other	☐ Prefer not to say	

Contact Details

House Name/Flat Number: .....

Door Number & Street: .....

Locality: .....

Town/City: .....

County: .....

Postcode: .....

Home Phone Number: .....

Work number: .....

Mobile Number: .....

Email Address: .....

Previous/Temporary Address:

House Name/Flat Number: .....

Door Number & Street: .....

Locality: .....

Town/City: .....

County: .....

Postcode:

Would you like EMIS Access?	☐ Yes	☐ No
Can we contact you via SMS Messages?	☐ Yes	☐ No
Can we contact you via E-mail?	☐ Yes	☐ No

Date entered Country, if from outside of EU:

About you (Parent or Guardian)

Name of Parent/Guardian registering child:

Parent/ Guardian Name:

Mother at same address? ☐ **Yes** ☐ **No**

If no, Please give details:

Mother Register at Practice? ☐ **Yes** ☐ **No**

Parent/ Guardian Name:

Father at same address? ☐ **Yes** ☐ **No**

If no, Please give details:

Father Register at Practice? ☐ **Yes** ☐ **No**

Your Childs Health

Approx. height: _____ Feet _____ Inches **OR** _____ CM

Approx. weight: _____ Stone _____ lbs **OR** _____ KG

Please list any other illnesses, accidents, hospital admissions, operations, broken bones, serious infections or investigation:

Date/Year	Nature of illness

Chlamydia Screening Test (16-24years only)

We are offering free STI screening to patients between 16-24 years due to rising rates of sexual transmitted infections. Often patients have no symptoms but the implications of being untreated can have serious long term consequences including infertility.

Would you like to have a Chlamydia screening test?	☐ Yes	☐ No

Allergies

Please list all allergies e.g. medications, hay fever, food, animals, ect

Family History

Have any of you blood relatives ever suffered from:

				Relationship	**Age at diagnosis**
Cancer, which type?	☐ Yes	☐ No	*Type:* •	•	•
Diabetes, which type?	☐ Yes	☐ No	•	•	•
Heart Attack / Angina / Heart Bypass/Stent	☐ Yes	☐ No	•	•	•
High Blood Pressure	☐ Yes	☐ No	•	•	•
Stroke	☐ Yes	☐ No	•	•	•

Medication

If you are on any regular medication please attach your repeat prescription slip from your last practice. If you do not have one please list any medications which you use regularly.

Drug Name	**Form (tablet, cream)**	**Strength**	**Amount taken per day**

Summary Care Records

The Summary Care Record is a copy of key information from your GP record. It provides authorised healthcare staff with faster, secure access to essential information about you when you need unplanned care or when your GP practice is closed. Please select one of the option below:

☐ **Express consent** *for medication, allergies and adverse reactions ONLY*

☐ **Express consent** *for medication, allergies, adverse reactions AND additional information e.g. reason for medication, significant medical history, anticipatory care, end of life information, communication preferences and immunisations*

☐ **Express dissent** (opt out) - *Patient does not want a Summary Care Record ~ please ask at reception for a form*

FOR OFFICE USE ONLY

☐ **Photo ID** ☐ **Proof of address** ☐ **NHS Number**

Receptionist ..... **Date** .....