SUTHERGREY HOUSE MEDICAL CENTRE
37a St John's Road, Watford, WD17 1LS

In order to be fully registered with this practice, this form MUST be completed by the parent/guardian

Registering a New Birth; the practice would like to congratulate you and would like to guide you in that it will require the Full Birth Certificate and Red Book in order to get baby Registered.

NEW BABY & CHILD QUESTIONNAIRE (FOR 0 TO 16 YEAR OLDS)			
TITLE:		**FIRST NAME:**	
SURNAME:			
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)
ADDRESS (incl flat no):		**WHO ELSE LIVES IN THIS HOUSEHOLD?**	
		IS YOUR CHILD THE LONE OR PARTIAL CARER FOR SOMEONE? If yes, please specify:	**YES** ☐ **NO** ☐ (please tick)
HOME TEL:		**MOBILE TEL:**	
EMAIL ADDRESS:			
WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad, child etc.)	**MOBILE:**		
	EMAIL:		
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?	**HOME:**	**YES** ☐ **NO** ☐ (please tick)	
	MOBILE:	**YES** ☐ **NO** ☐ (please tick)	
NEXT OF KIN: (Name, Address, Tel No.)			

Ethnicity ……

Please indicate your/their ethnic origin:

☐ British or mixed British ☐Polish ☐African ☐ Caribbean ☐ Indian ☐ Pakistani ☐ Irish ☐ Bangladeshi ☐ Chinese

☐ Other (please state): ☐ Decline to state

MEDICATION	
IS YOUR CHILD ON ANY REGULAR MEDICATION?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state name and dose: (Please note they will be required to see the doctor for a first repeat prescription to be issued)	
IS YOUR CHILD ALLERGIC TO ANY MEDICATION?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state type and name:	

MEDICAL HISTORY			
HAS YOUR CHILD HAD/STILL HAVE ANY OF THE FOLLOWING (please tick) **:**			
High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
If Asthmatic, have they used their inhaler in past 12 months?	**YES** ☐ **NO** ☐		
Please give details of any other illnesses, accidents, hospital admissions, investigations or operations your child has had :			
			Date:
			Date:
			Date:
			Date:

FAMILY HISTORY						
Has a first degree relative of your child (parent or sibling) suffered from any of the following conditions? (please tick)						
Cancer	**YES** ☐ **NO** ☐		**Who?**		**At what age?**	
Stroke	**YES** ☐ **NO** ☐		**Who?**		**At what age?**	
Heart Disease	**YES** ☐ **NO** ☐		**Who?**		**At what age?**	
Diabetes	**YES** ☐ **NO** ☐		**Who?**		**At what age?**	

Vaccinations

If your child is 0-7 Yrs kindly provide us with the information about your child immunisations that they have received. You MUST bring along any records you have in your RED Child Health Book (vaccination history/book) when you come to the Practice.

Age Due	Vaccine	Tick if Given	Date Given	At GP Surgery	Other
Birth Onward	**BCG, Hepatitis B course of 4 injection at birth,1,2 and 6mths**				
2 months	**1st 5-in-1 Vaccine, 1st Pneumococcal, 1st Rotavirus, 1st Men B**				
3months	**2nd 5-in-1 Vaccine, 2nd Rotavirus, 1st Men C (discontinued July 1st 2016)**				
4months	**3rd 5-in-1 Vaccine, 2nd Pneumococcal, 2nd Men B**				
12 months	**1st MMR, 3rd Pneumococcal, 3rd Men B, Hib/Men C,**				
2-6 years	**Children's flu vaccine (annual)**				
3yrs 4 Months	**4-in-1 pre-school booster, 2nd MMR**				

Immunisation records are very important for the wellbeing of your child. Collecting this information will ensure that we have an up to date record, including when the next vaccinations are due.

In line with the Government's new Child Protection procedures, we are now required to ask for specific information on all new patients registering with us under the age of 16 years.
We would very much appreciate your help in this matter, and any information you provide will be regarded as confidential.

1. Who is the main carer, e.g.: parent/guardian……
2. Name of current school……
3. Social Services involvement – yes/no……
4. If yes, please give name of Social Services/Social Worker……

I confirm that the information I have provided is true to the best of my knowledge.

Signature of Parent or Guardian ……
Date ……