Clapham Park Group Practice – Registration Form for ages 7-15

Please Complete in BLOCK CAPITALS and Tick ☑ as appropriate

CHILD'S PERSONAL DETAILS

TITLE *(e.g. Mr, Miss, Mx etc.)*:

FIRST NAME:	**MIDDLE NAME:**	**LAST NAME:**
PREVIOUS SURNAMES (IF ANY):		**DATE OF BIRTH:**
KNOWN AS/NICKNAME:		**NHS NUMBER:**

ETHNICITY *(e.g. White British, Asian, Caribbean, etc.)*:	**TOWN AND COUNTRY OF BIRTH:**
GENDER: ☐ **FEMALE** *(including trans female)* ☐ **MALE** *(including trans male)* ☐ **OTHER** *(please state)*:	**IS YOUR CHILD'S GENDER IDENTITY THE SAME AS THE GENDER THEY WERE GIVEN AT BIRTH?:** ☐ **YES** ☐ **NO**
MAIN SPOKEN LANGUAGE:	**DO YOU REQUIRE A TRANSLATOR?**

CONTACT DETAILS

HOUSE NAME/FLAT NUMBER:

NUMBER AND STREET:

TOWN/CITY:	**POSTCODE:**
HOME TELEPHONE:	**MOBILE TELEPHONE:**

EMAIL ADDRESS:

YOUR CHILD'S PREVIOUS MEDICAL RECORDS

YOUR CHILD'S PREVIOUS ADDRESS IN UK *(if no previous address, please state this)*:

House name/flat number:

Number and street:

Town/City:

Postcode:

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NAME AND ADDRESS OF PREVIOUS GP PRACTICE *(If no previous GP, please state this)***:**

IF YOUR CHILD IS FROM ABROAD AND HAS NEVER HAD A GP BEFORE:

DATE YOUR CHILD FIRST CAME TO LIVE IN THE UK:

ABOUT YOUR CHILD

HEIGHT:	**WEIGHT:**

WHAT ARE YOUR CHILD'S PREFERRED PRONOUNS?:

- ☐ **HE/HIM**
- ☐ **SHE/HERS**
- ☐ **THEY/THEM**

PLEASE PROVIDE DETAILS OF ANY SIGNIFICANT MEDICAL HISTORY OR CONDITIONS YOUR CHILD HAS:

PLEASE DETAIL ANY RELEVANT MEDICAL HISTORY IN YOUR CHILD'S IMMEDIATE FAMILY:

ILLNESS	**FAMILY MEMBER (Eg Brother,Mother, etc)**
☐ **HIGH BLOOD PRESSURE**	
☐ **DIABETES**	
☐ **MENTAL ILLNESS**	
☐ **STROKE**	
☐ **CANCER**	
☐ **HEART ATTACK**	
☐ **ASTHMA**	

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PLEASE PROVIDE DETAILS OF ANY ALLERGIES YOUR CHILD HAS AND THEIR REACTION:

PLEASE PROVIDE DETAILS OF ANY MEDICATION YOUR CHILD IS CURRENTLY PRESCRIBED:

IS YOUR CHILD SUBJECT TO A CHILD PROTECTION PLAN?	
☐ YES:	☐ NO

IS THE CHILD IN FOSTER CARE/PRIVATE FOSTER? (Please provide documentation to the practice where applicable)	
☐ YES:	☐ NO

PLEASE SELECT A PHARMACY TO HAVE ANY FUTURE PRESCRIPTIONS SENT TO ELECTRONICALLY (If you do not select a pharmacy, we will automatically set your pharmacy as Phillips Pharmacy, 70A Clarence Avenue, London, SW4 8JP)
Please enter the full address of your pharmacy:

NEXT OF KIN/EMERGENCY CONTACT #1 FOR CHILD:	
NAME OF NEXT OF KIN **Title:** **First name:** **Surname:**	**RELATIONSHIP TO PATIENT** (e.g. mother, father, etc.)
Telephone number:	**Email address:**

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IS THE ABOVE PERSON REGISTERED/REGISTERING AT CLAPHAM PARK GROUP PRACTICE?	☐ **YES** ☐ **NO**
NEXT OF KIN/ EMERGENCY CONTACT #2 IF APPLICABLE:	
NAME OF NEXT OF KIN **Title:** **First name:** **Surname:**	**RELATIONSHIP TO PATIENT** (e.g. mother, father, etc.)
Telephone number:	**Email address:**
IS THE ABOVE PERSON REGISTERED/REGISTERING AT CLAPHAM PARK GROUP PRACTICE?	☐ **YES** ☐ **NO**
SIGNATURE OF PERSON(S) WITH PARENTAL RESPONSIBILITY:	
SIGNATURE(S):	**DATE:**