Bradford Street Surgery, 65 Bradford Street, Bolton, BL2 1HT

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

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| Child’s Full Name |  |
| Child’s Date of Birth |  |
| Child’s Place of Birth |  |
| Mother’s Full Name |  |
| Father’s Full Name |  |
| Name of Person (s) Who Has Parental Responsibility |  |
| Who Lives In The Household With The Child | Name: Relationship to the child: |
| Ethnicity |  |
| Main Spoken Language |  |
| Preferred Communication Method |  |
| Gender Identity | Which of the following best describes how the child thinks of themselves:  Male (including Trans Male)  Female (including Trans Female),  Prefer not to say  In another way ……………………… |
| Is the Childs gender identity the same as the gender they were assigned at birth? (please tick one option)  Yes  No  Prefer not to say  We ask these questions on gender identity to help us understand how we can support a childs health needs, please let us know if you wish to discuss this further: ……………………………………… |
| Child’s Current Nursery/School/College |  |
| Current Address |  |
| Previous Address |  |

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| --- | --- | --- |
|  | | **If yes, please provide further details** |
| Does the child have any medical conditions? | Yes/No |  |
| Does the child have any additional needs? | Yes/No |  |
| Does the child take any regular medicines? | Yes/No |  |
| Does the child have any allergies? | Yes/No |  |
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| **6-8 Week Check + Immunisations Data** | | **If yes, please provide further details** |
| **NEW BABIES ONLY** – Has the child had their 6-8 week baby check with the GP? | Yes/No |  |
| Is the child up to date with their immunisations?  (If yes, move onto the next question) | Yes/No |  |
| Have they had all of their childhood immunisations in England?  (If no, move onto the next question) | Yes/No |  |
| Have they had their childhood immunisations in a different country?  If yes, please state which country and provide us with written proof or a verbal history where possible | Yes/No |  |
| **Please do not leave the above section blank. If you do not wish to have the child vaccinated as per the immunisation schedule, a refusal form will need to be completed. Please ask at reception for one of these.** | | |
|  | | |
| **Parental Responsibility for the child:** | | **If yes, please provide further details** |
| Is the child you are registering looked after by the local authority?  If yes, please give details of care order, parental responsibility, carers details etc | Yes/No |  |
| Does your family have a social worker? | Yes/No |  |
| Is your child a carer? If yes, for whom?  For more support check out: <http://www.bolton.gov.uk/website/pages/Youngcarers.aspx> | Yes/No |  |

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| --- | --- |
| Name of person completing this form |  |
| Relationship to the child |  |
| Signature |  |
| Date |  |
| For Practice use: | |
| 0-19 Service informed of new child registration  Email: [boh-tr.CYPDAdmin@nhs.net](mailto:boh-tr.CYPDAdmin@nhs.net) | Y/N  Date notification sent:  Signed by Practice: |