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 sayWe 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 registrationEmail: boh-tr.CYPDAdmin@nhs.net | Y/NDate notification sent:Signed by Practice: |