Collection fields to be trialled at registration of child or young person under 18 years of age.

REGISTRATION FORM FOR CHILD OR YOUNG PERSON

Surgery Details:		Date form completed:				
		NHS Number if known:				
Details of child being registered						
Surname:		Forename(s):				
Date of Birth :		Sex: Male / Female				
Current Address :		Contact details				
		Home Tel.: Mobile No:				
		Woodie Wo.				
Post Code :						
First language spoken:		Religion:				
Ethnic origin:		Place of birth:				
Name of School/Nursery		Has the child been known by any other name : YES				
		/NO				
		If yes please give details:				
Name and address of againing CD:		Previous address if from abroad:				
Name and address of previous GP:		Previous address ii from abroad:				
		Date first came to UK:				
		Date first came to ok.				
Details of Childs Main Carer:						
Surname:	Firs	First Name:				
Current address (if different from child's):	Con	Contact details (if different from above):				
·		nsent to be contacted by text message Yes/No				
father - specify)						
Does the child have contact with the father: YES / NO						
Surname:		First Name:				
Current address (if different to child's):		Contact details (if different to child)				

REGISTRATION FORM FOR CHILD OR YOUNG F	PERSON	Page 2 of 2	
Childs Surname:	Childs Forename:		
Any other significant carers involved in the upbri grandparent or Foster carer)	inging of this child o	or young person (eg Stepfath	er, aunt,
If yes please give details:			
Are any other services known or involved with fa If yes, please give details:	amily or young pers	on? Eg Social Care, CAMHS:	YES / NO
Does the child have any disabilities or distinguish	ning features? YES,	/ NO	
If yes, please give details:			
Please state any significant medical history :			
Is the patient on any repeat medication? YES / N If yes please give details:	10		
Does the child suffer from any allergies? YES / NO)		

If yes please give details:

Is there any significant family history? ie. Asthma/Heart conditions

Is the child or YP a smoker?: YES / NO Does the child consume alcohol? YES / NO

HOUSEHOLD COMPOSITION									
Please list all persons (adults and children) who live at the address with this child									
Surname	First Name	DOB	Occupation/School	Relationship to child ie.	Registered at surgery				
			Nursery	Sibling/aunt etc	(Yes/No)				