**UNDER 16 REGISTRATION STATUS FORM**

Tel: 01332 340381 1 [www.macklinstreetsurgery.co.uk](http://www.macklinstreetsurgery.co.uk)

Thank you for applying to join Macklin Street Surgery. We would like to gather some information about you and ask that you fill in the following questionnaire. You don’t have to supply answers to all of the questions but what you do fill in will help us give you the best possible care.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.

**Fields marked with a \* and highlighted yellow are mandatory, failure to complete these sections may result in your registration not being processed.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| \*Child’s Surname: | | |  | | \*Child’s first names: | | |
| \*Male Female | | |  | | \*Date of Birth: | | |
| \*Town and country of birth: | | |  | | \*NHS No.  (If known) | | |
| \*Child’s home address: | | |  | | **Previous Doctor’s details** | | |
| \*Post code: | | |
| \*Mobile Telephone No: | | |
| \*Home Telephone No : | | | \*Name of previous doctor | | |
| \*Previous address: | | | Address of previous doctor | | |
|  | | |  | | |
| \*Do you consent to the share NHS Summary Care Record (SCR)? Yes No (Please Circle) | | | \*If previously a resident in the UK, date of leaving; | | |
| **More details concerning the Summary Care Record and what it means to you can be found by visiting: www.nhscarerecords.nhs.uk** | | |  | | \*Date you first came to live in the UK if applicable; | | |
|  | |
|  | |
| **Further Information** | | |  | |  | | |
| Parent/Guardian’s Name: | | |  | | What is/will be the child’s first language: | | |
| Parent/Guardian’s Address: | | | Do you require an Interpreter:  Yes / No | | |
| Relationship to Child: | | | Is Social Care involved with family or child?  Yes / No | | |
| **Child’s immunisation history** **(6 or under)** | | | | | | | |
| Do you have the child’s ‘Personal Child Health Record’ (Red Book?)  Yes – Please pass to reception to copy immunisation information. | | | | | | No – Please provide a list of the child’s immunisation history. | |
| **Child’s School Details** | | | | | |  | |
| Name of child’s current school: | | | | | | | |
|  | | | | | | | |
| **What is the child’s ethnic group** | | | | | | | |
| **White** | British | Irish | | | | |  |
| **Black** | Caribbean | African | | | | |  |
| **Asian** | Indian | Pakistani | | | | | Chinese |
| **Mixed** | White + Black Caribbean | White + African | | | | | White + Asian |
| **Other** | Please Specify | | | | | | |
| **A ‘person with parental responsibility’ means someone with the rights and responsibilities that parents have in law for their child. Including the right to consent to medical treatment for them, up to the age of 18 years in England, Wales and Northern Ireland, and up to 16 years in Scotland.**  **Mothers and married fathers have parental responsibility, and so do unmarried fathers of children registered since 15th April 2002 in Northern Ireland, since 1st December 2003 in England and Wales and since 4th May 2006 in Scotland, as long as the father is named on the child’s birth certificate. Parents do not lose parental responsibility if they divorce.** | | | | | | | |
| \*Who has parental responsibility?  Mother Father Both Other  If Other please specify: | | |  | | \*Named of individual with parental responsibility: | | |
|  | | Signature: | | |
| **IF BOTH PLEASE LIST SECOND PARENT’S DETAILS BELOW** | | | | | | | |
| Second Parent’s Name and relationship to child: | | |  | | Second Parent’s Address: | | |
|  | |
| **IF THERE IS ANYONE ELSE RESIDENT AT THE SAME ADDRESS AS THE CHILD, PLEASE LIST THEM BELOW:** | | | | | | | |
| Name:  Details of school IF different from above: | | | | Relationship to the child: | | | |
| Name:  Details of school IF different from above: | | | | Relationship to the child: | | | |
| Name:  Details of school IF different from above: | | | | Relationship to the child: | | | |
| Name:  Details of school IF different from above: | | | | Relationship to the child: | | | |

|  |
| --- |
| Can we have consent to view incoming information from other medical providers, and for us to send out information to other medical providers? (for example; being able to view Health Visitor reviews can help us to monitor child development):  Yes / No |

|  |
| --- |
| Does the child have any allergies? Yes / No |
| If Yes – please detail what allergies; |
| \*Signature of individual completing form:  \*Date |

\***Please view our privacy notice on our website; www.macklinstreetsurgery.co.uk**