Haverthwaite Surgery

Patient registration and health questionnaire - Child

Full name		**Date of birth**	
Gender		**Ethnicity**	eg white British, Asian British
Email address			
Dispensing	YES / NO	**If no, please provide name & postcode of preferred pharmacy**	
Consent for SMS from practice	YES / NO	**Consent for email from practice**	YES / NO
Next of kin [NOK]: name and address			
Relationship to NOK			
NOK telephone		**NOK email**	
Contact NOK in emergency	YES / NO	**Consent to share medical info with NOK**	YES / NO
Consent to share medical information with other NHS services eg hospitals, district nurses			YES / NO

Please indicate if any of the following apply to your child:		**Please indicate if your child has any of the following health conditions:**	
They are registered blind/partially sighted	YES / NO		
They are registered deaf	YES / NO	Diabetes	YES / NO
They are registered disabled	YES / NO	Hypertension [raised blood pressure]	YES / NO
They are housebound	YES / NO	Stroke/TIA	YES / NO
They have a carer	YES / NO	Asthma/COPD	YES / NO
They are a carer	YES / NO	Heart problems	YES / NO
Please provide any relevant details			

If you want the practice staff to be aware of any other issues, please provide some information	
Does your child have any drug allergies? *Please include known reactions*	
Does your child have any other allergies? *Please give as much detail as possible*	

PARENT OR GUARDIAN DECLARATION

I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.

Signature		**Print name**	
Date		**Relationship to child**	

Please pass your completed form to a member of the reception team. Thank you