Freshwell Health Centre

Registration form for young person aged 0 to 15 years inclusive

Surgery Details: Freshford Practice Freshwell Health Centre Wethersfield Road Braintree Essex CM7 4BQ
Date form completed:

Details of child/young person being registered

Surname:	**Forename(s):**
Date of Birth: **Gender:**	**NHS Number (if known):**
Current Address: **Postcode:**	**Contact telephone details** **Home:** **Mobile:**
First language spoken:	**Second language spoken:**
Religion:	**Place of birth:**

Ethnicity (please tick one box)			
African		White & Black African	
Bangladeshi / British Bangladeshi		White & Asian	
British/Mixed British		Other Asian background	
Caribbean		White & Black Caribbean	
Indian / British Indian		Other white background	
Irish		Other	
Pakistani / British Pakistani		Other mixed background	
Welsh		Ethnic category not stated	

Name of nursery/school (if applicable):	**Has the young person been known by any other name(s): Yes No** **If yes please give details:**
Name and address of previous GP (if applicable):	**Previous home address if moved in from overseas:** **Date first came to UK:**

Details of young person's main carer

Surname:	**First Name:**
Current address (if different from above):	**Contact telephone number (if different from above):** **Home :** **Mobile:**
What is the relationship to the young person (eg Mother, Father please specify):	**Consent to contact by text message:** **Yes** **No**
Does the young person care for a friend or relative?	

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If the young person does not live with a parents please detail who has parental responsibility and if appropriate any access/custody agreements in place. This information will assist the practice to offer continuity of care:

For all young persons aged under 16 years please indicate who will give consent for immunisations given at the practice, further documentation may be requested:

Next of Kin
Name: **Contact Telephone Number:**

Are there any other significant carers involved in the upbringing and wellbeing of the young person (eg step parent, foster carer). If yes please give details:

Are any other services known or involved with the young person or family? (eg CAMHS, Social Services) If yes please give details:

Does the young person disabilities or additional needs the Practice should be aware of in order to ensure best care is given? If yes please detail below

Height and Weight Measurements
Please record this information if you have accurate and up to date values

Height	**cm**	**or**	**inches**
Weight	**cm**	**or**	**inches**

Please detail any significant medical history:

Is the young person currently taking any regular/repeat medication? If yes please detail below:

Does the young person suffer from any allergies? If yes please detail below:

Are there any significant medical family history such as asthma or heart conditions? If yes please detail below:

Are there smokers in the household? Yes No

Is the young person a smoker? Yes No

Smoking cessation is available at the practice

Does the young person consume alcohol?
Yes No

If yes please state the number of units drunk per week

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Household Composition: Please list all persons (adults and children) who live with this young person					
Surname	**Forename**	**DOB**	**Occupation / school / nursery**	**Relationship to young person**	**Registered at this practice (yes / no)**

Please use additional paper and securely attach to this form if required.

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