**Children Registration Form: UNDER 16s**

We need some information about you as soon as you register as your medical records can take several weeks to arrive. Please complete all the questions below.

*The Practice is required to process patient’s personal and special category data in various situations. Detailed information on how and why we do this can be found at* [*www.westtimperleymedicalcentre.co.uk*](http://www.westtimperleymedicalcentre.co.uk)*.*

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forenames |  |
| Any Previous Surnames |  | Date of Birth |  |
| NHS number(if known) |  | Employment Status |  |
| Landline Number |  | Mobile Number |  |
| Email |  |
| Next of Kin | Contact |
| Do you consent to being contacted via text?  | Yes No |
| Do you consent to being contacted via email? | Yes No |

|  |  |
| --- | --- |
| Do you want to set up Online Access? | Yes No |
| If you would like online access for a child up to age 11 you will need to complete a proxy access form to act on their behalf. Please visit our website https://www.westtimperleymedicalcentre.co.uk/ and go to the New Patient page where you will find the Proxy Access Form or request a form from reception. You will need to complete this form and either email it or bring it in with ID and proof of parental responsibility for us to set this up. |

**Please note it is your responsibility to ensure we have up to date contact details on your records.**

|  |  |
| --- | --- |
| First language (if not English) |  |
| Do you have any communication needs? | Yes No |
| If yes please explain |  |
| Who has parental responsibility? |   |
| Do any other adults live in the family home? |  |
| Family Social Worker details (if applicable) |  |
| Childs School |  |
| Does the child have a disability? Please specify |  |

Child Immunisations

**It is essential that you provide us with a list of your child’s immunisations to ensure he/she is fully protected and called appropriately for future vaccinations.**

Please provide us with a copy of your child’s immunisations so that the Practice Nurses can review and update your child’s records.

Ethnicity

*The Practice has been asked to request this information as part of the Department of Health’s commitment to race equality. This information is NOT mandatory. If you are happy to answer please tick ONE box.*

|  |  |  |  |
| --- | --- | --- | --- |
|  | White |  | Black Caribbean |
|  | White British |  | Black African |
|  | White Irish |  | Other Black Background |
|  | Indian |  | Chinese |
|  | Pakistani |  | Other Asian Background |
|  | Bangladeshi |  | Other Ethnic Group |
| If other please list |  |
|  | **Do not want to state ethnicity** |   |

**YOUR** Family History

*If any of your immediate family were diagnosed with any of these illnesses please tick the correct box*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Mother | Father | Sisters | Brothers |
| Asthma |  |  |  |  |
| Diabetes |  |  |  |  |
| Stroke/TIA |  |  |  |  |
| Heart Disease |  |  |  |  |
| High Blood Pressure |  |  |  |  |

**YOUR** Health

|  |  |
| --- | --- |
| Do you suffer from any allergies or have you had a reaction to any medication? | Yes No |
| If yes, please detail: |
| **Have you ever suffered from?** |
| Epilepsy | Yes No | Glaucoma | Yes No |
| Hypothyroidism | Yes No | High Blood Pressure | Yes No |
| Diabetes Type 1 | Yes No | Stroke/TIA | Yes No |
| Diabetes Type II | Yes No | Heart Disease | Yes No |
| Depression | Yes No | Mental Health | Yes No |
| Cancer | Yes No | COPD | Yes No |
| Asthma | Yes No |  |
| Other Serious or Chronic Illnesses (please list) |  |

|  |  |
| --- | --- |
| Do you take any regular prescribed medication? | Yes No |
| *If yes please provide us with an up-to-date re-order slip from your old practice so we can review this.*  |

**Information for new patients: about your Summary Care Record**

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
3. **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

NHS Number (if known): …………………………..………………...........................................................

Signature: ………………………………………………………….. Date: ………………………………………………

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

 for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to the practice.