**Welcome to the Belmont Health Centre (Children 0-15 years)**

Thank you for completing this questionnaire. All information you give is confidential and will be held on you medical records. Please can you:

Complete **both sides** of this form, writing clearly and in **BLOCK CAPITALS**

Provide a specimen of Urine

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Date of birth |  |
| Email address  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| We may occasionally communicate with you by SMS or email. We will not pass your email address or phone number to any non-NHS organisation. Tick here if you do NOT wish to be contacted by email or SMS. [ ]  |
| **Who should we contact in an emergency?** |
| Name of carer |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship |  |
| Telephone number |  |

**Ethnicity**

What is your country of birth? What is your first language?

[ ]  White British

[ ]  Other White ethnic group

[ ]  Black British

[ ]  Black Caribbean

[ ]  Black African

[ ]  Black other

[ ]  Other Black ethnic group

[ ]  Indian

[ ]  Pakistani

[ ]  Bangladeshi

[ ]  Chinese

[ ]  Vietnamese

[ ]  Other Asian ethnic group

[ ]  I do not wish to state my ethnic group

[ ]  Other ethnic group (please state):

**Religion**

[ ] No religion

[ ] Christian

[ ] Buddhist

[ ] Hindu

[ ] Jewish

[ ] Muslim

[ ] Sikh

[ ] Any other religion (please state)

[ ]  Vietnamese

**Additional Information**

Is this child under any social care order? [ ]  Yes [ ]  No

Is this child a ‘looked after’ child? [ ]  Yes [ ]  No

Is there any history of fits/epilepsy or TB? [ ]  Yes [ ]  No

If yes please give details: ……………………………………………………………………………………………………………………………………………………………

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Please list any serious illnesses, accidents, operations or disabilities

(Please state hospital and year)

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**IMMUNISATIONS**

**REQUIRED DOCUMENTATION**

* RED BOOK
* ROUTINE CHILDHOOD IMMUNISATION & NON-ROUTINE IMMUNISATION/VACCINATION HISTORY

Staff Checklist:

1. Red book seen / Imms history provided
2. Red book not seen / Imms history to be advised

[ ] Imms pages copied

[ ] Patient will bring in

**Drugs and Medications**

If you require any medication, you must make an appointment with a Doctor for this to be issued. Please bring your repeat medication slip or attach your last prescription.

**Thank you for your time and help in completing this questionnaire**

*Issuing of the registration documents does not guarantee registration with this Practice*

**For office use only**

**Proof of ID seen:** [ ]  Yes [ ]  No

Document Initials/Date

**Proof of address seen (e.g. Utility bill):** [ ]  Yes [ ]  No