HUDDERSFIELD ROAD PARTNERSHIP

NHS FAMILY DOCTOR SERVICES REGISTRATION FOR UNDER 16'S

Patient Details — Please complete in BLOCK capitals and tick ☑ as appropriate

Name of child: **Any previous names:**	**Address:**
Date of Birth:	**Telephone Number:**
☐ **Male** ☐ **Female**	**Allergies:**
Height if known:	**Weight if known:**
Smoker: Yes/No	**Is the child fully immunised: Yes/No**
Does the child suffer from (please tick): **Asthma ( )** **Epilepsy ( )** **Diabetes ( )** **Any other disability or long term condition:**	**Is there any family history of:** **Heart Disease Yes/No** **Relationship:** **Stroke Yes/No** **Relationship:**
Is the child taking any current medication:	**Name of Parent/Carers:** **Parent……..** **Carer……**
Name of School attended:	**Name of social Worker (if applicable):**
If you are registering a child under 5, please complete the following ☐ **I wish for the child above to be registered for Child Health Surveillance**	
☐ **Signature of patient** ☐ **Signature on behalf of patient** **Date:**	

Please tick the box below that most accurately describes your national identity and ethnic origin. This information will be treated in the strictest confidence.

	Please Tick		Please Tick
British or mixed British		Pakistani or British Pakistani	
Irish		Bangladeshi or British Bangladeshi	
Other white background		Other Asian Background	
White & Black Caribbean		Caribbean	
White & Black African		African	
White & Asian		Other Black Background	
Other Mixed Background		Chinese	
Indian or British Indian		Other Ethnic Category (Please State)	

First Language:	
Do you need an interpreter	Yes/No

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