NEW PATIENT REGISTRATION - CHILD QUESTIONNAIRE

Thank you for registering your child with our Practice. We would be grateful if you could answer some background details so that we have useful information while waiting for medical records to arrive from your previous surgery.

Please complete in block capitals

Surname	
First Name (s)	
Full Address **(including Postcode)**	
Home Phone Number	

What is your child's first language? …………………………………………………

Immunisations/Injections	Age Due	Date Given – if known
Diptheria/Tetanus/Pertussis/Polio/Haemophilus Influenzae Type b (DTaP/IPV/Hib) **Pneumococcal Vaccine**	2 months	
Diptheria/Tetanus/Pertussis/Polio/Haemophilus Influenzae Type b (DTaP/IPV/Hib) **Meningitis C**	3 months	
Diptheria/Tetanus/Pertussis/Polio/Haemophilus Influenzae Type b (DTaP/IPV/Hib) **Meningitis C Vaccine & Pneumococcal Vaccine**	4 months	
Haemophilus Influenzae Type b **Meningitis C**	12 months	
Measles, Mumps & Rubella (MMR) **Pneumoccocal Vaccine**	13 months	
Diptheria/Tetanus/Pertussis/Polio (DtaP/IPV/Hib) **Measles, Mumps & Rubella (MMR)**	Four years	
Girls Only : HPV for cervical cancer	12-18 years	
Diptheria, Tetanus and Polio	13-18 years	
Other Injections		

Has your child been diagnosed with any significant illnesses (i.e. asthma, diabetes, epilepsy)?	
Does your child suffer from any allergies? If so, what?	
Is your child on any medication? If so, what?	

Which school does your child attend / will your child be attending?
…………………………………………………………………………….

Parent/Guardian's Signature: **……………………………………….**

Date: ……………………

March 2010