



CHILD / Young Person (under 16) Registration

Welcome to Wellington Practice.

Please complete the registration form below.

Once you are on the system you will receive a couple of text to confirm

1. That you are registered
2. Where to find the additional patient information on our website regarding:
 - i. Patient Online access
 - ii. National data Opt Out
 - iii. Privacy Notice
3. Who your usual GP is
4. Any medication review needed (only if relevant)

Has the child or family either currently or in the past been known to Children's Services?

Yes No

Name of Social Worker:

Social Worker's Phone No:

Required Information:

Is your child looking after someone at home? Yes No

If so, who³?

³ Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

What is the adult's relationship to the child?

Do you think the child would like additional support as a young carer? Yes No

Is the child known to services such as Young Carers? Yes No

Is the child being privately fostered (*see definition below*)? Yes No

If yes, please provide carer's name:

Carer's relationship to child:

Contact details of carer:

Are Children's services aware? Yes No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) ([S.66 Children Act 1989](#)) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person'. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, **but cannot be a relative** as defined under the [Children Act 1989, section 105](#): 'A relative under the Children Act 1989 is defined as a 'grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent'.

Please help us trace the child's previous medical records by providing the following information:

Your previous address in the UK:

Name of previous Doctor while at that address:

Surgery Name and Address of previous Doctor:

If you are from abroad:

Your first UK address where Registered with a GP:

If previously resident in UK date of leaving:

Date you first came to the UK:

If registering a child under 5:

I wish the child above to be registered with Wellington Practice for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*:

For Dispensing Practices only:

I live more than 1 mile in a straight line from the nearest chemist

Patient Declaration for all patients who are not ordinarily resident in the UK:

Please see appendix 1 for patient declaration (last page of form)

Child's Personal Medical History:

If under 5 years old, type of Birth:
(eg normal, forceps, caesarean)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

Condition	Year Diagnosed	Ongoing
		Yes/No
		Yes/No

Family Medical History:

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

	Heart Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal/Kidney	Learning Difficulties
At the time of diagnosis they were:										
Over 60 yrs old										
Under 60 yrs old										

Child's Immunisations:

Please provide details of your child's immunisations with dates if possible (under 5's). If possible please give your Red Book to Reception to photocopy:

Immunisation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles			
MMR			
BCG (TB)			
Meningitis			

Child's List of Current Medication:

Name of Medication	Dosage

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Patient's Details

Please complete in BLOCK CAPITALS and tick ✓ as appropriate

Mr Mrs Miss Ms

Surname:

Date of Birth

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First Names:

NHS No.

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Previous Surname/s:

Male Female

Town and Country of Birth:

Home Address:

Postcode:

Telephone No:

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Scan and send this page of form to: NHSDigital-EHIC@nhs.net

Summary Care Records

My Choice

Wellington Practice

Forename (s)

Surname

Date of Birth

Signature Date

	Tick (only ONE) box as applicable
<p>1. Yes I would like a Summary Care Record created containing my medications, allergies and adverse reactions or sensitivities to medications</p> <p>This summary record will be held on an NHS Central Database and may be used in an emergency when your GP surgery is closed</p>	<input type="checkbox"/>
<p>2. Yes I would like a Summary Care Record created containing my medications, allergies and adverse reactions PLUS additional important information held on my GP record (e.g. diagnoses – Asthma (Lung disease), Kidney disease, Renal disease, Epilepsy, Cancer etc, and end of life requests)</p> <p>AND / OR I will come and see my GP to discuss any additional information I would like added to my Summary care Record as soon as possible</p>	<input type="checkbox"/> <input type="checkbox"/>
<p>3. No I do not want a Summary Care Record</p> <p>Please be aware that if you choose not to have a Summary care Record healthcare staff may not have access to important information about you in an emergency but be assured that you will be cared for to the best of their ability</p>	<input type="checkbox"/>
<p>1. Declined to share upload to local shared record (MIG)</p>	<input type="checkbox"/>

If you do **NOT** want your anonymised data shared with the national database for research and development use, you will need to visit the following website and enter your NHS number plus a few details about yourself.

This then means your data from the surgery record will not be uploaded to the National Data Team for them to use as part of their statistical research purposes.

No personal identifiable data is uploaded if you do not register onto their site to remove yourself from the data upload.

<https://www.nhs.uk/your-nhs-data-matters/manage-your-choice/>

TEXT SERVICE

For ease of communication we would like to send you (your parents / guardian as appropriate) a text to remind you of your appointment or to say that your results are in and can you call the surgery. We may also use text service to ask you to book a review appointment or a flu vaccination being a number of other things we need to communicate to you. This might for some people not be desirable. So that we can record consent or declining this service please can you tick one of the boxes below.

Your number will **NOT** be used by any other third party – it is only for our use to contact you. However it is **YOUR** responsibility to keep us informed of the correct mobile number to use and for any information sent to you to be in your control. If you choose to share, we cannot be held responsible.

We cannot text where the patient is under 16 years of age. If you wish to have a reminder text for your child under the age of 16 you will need to record a parent or responsible guardian mobile number and explicitly state whose number it relates to

I give consent for Wellington Practice to text me relevant information or reminders	<input type="checkbox"/>
I DO NOT give consent for Wellington Practice to text me relevant information or reminders	<input type="checkbox"/>

I give consent for Wellington Practice to text me relevant information or reminders on behalf of my son / daughter as detailed below	
Name of son / daughter	<input type="checkbox"/>
Name of son / daughter	<input type="checkbox"/>
Name of son / daughter	<input type="checkbox"/>
My name for consent is	
And my role is that of (circle the one that applies to you)	
Mother / father / legal guardian being	
And I confirm I have parental responsibility to sign this consent	<input type="checkbox"/>

