SELHURST MEDICAL CENTRE

CHILD REGISTRATION FORM

Registration for new/temporary patient between 10.30am – 11.30pm MONDAY – FRIDAY. Please speak with reception if the above time is not convenient

PERSONAL HISTORY		
FIRST NAME:		
SURNAME:		
ADDRESS:		
DATE OF BIRTH :		
GENDER:	MALE / FEMALE	
PLACE OF BIRTH		
NATIONALITY		
PARENT/GAURDIAN CONTACT NUMBER	HOME:	MOBILE:
MOTHER		
FATHER		
SIBLINGS		
NEXT OF KIN:	NAME:	
	RELATIONSHIP:	
	NOK REGISTERED AT SELHURST MEDICAL CENTRE? YES / NO	
	ADDRESS:	

	CONTACT NO:
	CAN DISCUSS RECORD: YES /NO
Name of school or nursery	
Main language spoken	

MEDICAL AND FAMILY HISTORY	
Any present illnesses? If yes, please state	
Any regular medication? If yes, please list here	
Any serious operations/diseases/illnesses?	YES /NO
Any known allergies – medicine/other	

LIFESTYLE	
Childs current	Height ………………….. Weight ………………………
How much exercise does your child do regularly?	Light Moderate Heavy
Does you child eat a varied diet? Including milk, meat, Vegetables and fruit	YES/ NO

	Dates
1st DTP, polio + HIB	
2nd DTP, polio + HIB	
3rd DTP, polio + HIB	
1st Meningitis C	
2nd Meningitis C	
3rd Meningitis C	
1st Pneumococcal	
2nd Pneumococcal	

3rd Pneumococcal	
1st MMR	
2nd MMR	
Pre-school booster (DTP, Polio)	
BCG	

DTP = Diphtheria Tetanus Pertussis

ETHNICITY

White-British ☐ Mixed-Asian/White ☐ Indian ☐

White-Irish ☐ Mixed-any other ☐ Pakistani ☐

White-other White ☐ Black African ☐ Bangladeshi ☐

Mixed-Black Caribbean/White ☐ Black-Caribbean ☐ Asian-other ☐

Mixed-Black African/White ☐ Black-other ☐ Chinese ☐

Any other ethnic group ☐