SOUTH LEWISHAM GROUP PRACTICE

REGISTRATION for CHILD AGED 6-16 Years

****(Please complete all of form using block capitals**

SURNAME: _____

FORENAME(S): _____

FORMER SURNAME (IF APPLICABLE) _____

ADDRESS: _____

TOWN: _____ **POSTCODE:** _____ **TEL. NO:** _____

DATE OF BIRTH: _____ **SEX (M/F)** _____ **NHS NO.** _____

PLACE OF BIRTH (TOWN AND COUNTRY) _____

ETHNIC ORIGIN: _____ **Main LANGUAGE:** _____

PARENT/CARERS NAME: _____

PREVIOUS ADDRESS DETAILS:
(last U.K. address where child was registered with a GP)

_____ **Post code:** _____

Name of previous GP _____

Previous GP Address: _____

DATE CHILD FIRST CAME TO LIVE IN UK (IF APPLICABLE) _____

IF PREVIOUSLY RESIDENT IN UK DATE CHILD LEFT: _____

Has the child been diagnosed as suffering with either of the following:

ASTHMA – YES/NO **DIABETES – YES/NO**

**** Please note if they suffer with any of the above you will need to attend the appointment that has been booked for a review of their current Health Status. If you do not attend the appointment your registration will not completed fully.**

Does the child have any ***ALLERGIES***?

NO □

YES □ ⟶

Please list them…..

_____

_____

Are they taking any regular ***PRESCRIBED*** medicines/tablets?

(THEY WILL NEED A GP APPONTMENT BEFORE ANY OF THEIR REGULAR MEDICINES CAN BE ISSUED FOR THE FIRST TIME)

NO □

YES □ →

Please list them showing the name strength & dosage or attach a copy of your latest repeat medication list from your previous doctor.

_____

_____

_____

_____

_____

(For Practice Use Only)

Forms taken and checked by: _____

Initials of Accepting Receptionist_____ Signature of GP _____

GP LNS Number _____ Date: _____