SOUTH LEWISHAM GROUP PRACTICE
APPLICATION TO GO ON DOCTOR'S LIST

CHILD AGED From 6 TO 16 YEARS

****(Please complete all of form using block capitals & you MUST bring in the Childs Red Health Book & Birth Certificate)**

SURNAME: ____________________

FORENAME(S): ____________________

FORMER SURNAME (IF APPLICABLE) ____________________

PARENTS/CARERS NAME: ____________________

ADDRESS: ____________________

TOWN: __________ **POSTCODE:** __________

TEL. NO: __________ **Mobile Number:** __________

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

PLACE OF BIRTH (TOWN AND COUNTRY) ____________________

ETHNIC ORIGIN: ____________________

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

____________________ **Post code:** __________

Name of previous GP ____________________

GP Address: ____________________

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

IF PREVIOUSLY RESIDENT IN UK DATE CHILD LEFT: ____________________

Please make sure you also complete immunisation & health data on the 2nd page of this form. We will not be able to register your child unless all of the form is completed

Immunisation data

Imms given	Date Given	Not Given	Imms given	Date Given	Not Given
BCG		☐	3rd DIP/TET/ POLIO IPV & HIB		☐
1st DIP/TET/ POLIO IPV & HIB		☐	2nd PCV		☐
1ST PCV		☐	1st MMR / 3rd PCV		☐
1st Rotavirus		☐	HIB/ MENC		☐
1st Men B		☐	2nd Men B		☐
2nd DIP/TET/ POLIO IPV & HIB		☐	2nd MMR		☐
2nd Rotavirus		☐	Pre-school Booster DTP/IPV		☐
From 14years of age					
Low dose DTP		☐	1st HPV		☐
2nd HPV		☐	3rd HPV		☐

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…..

____

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(For Practice Use Only)

Reception Initials ______________________ Date taken by reception: ________________

Name of Accepting GP ________________________ Signature of GP _______________________

Parent/Carer Registered @ SLGP**: YES/NO** Date: __________________________