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CONFIDENTIAL MEDICAL REGISTRATION FORM – Child aged 12 and under

Please complete all sections and pages in FULL using BLOCK capitals and CIRCLE as appropriate

Personal Details:

Full name..... Date of birth.....

Address.....

Male / Female / Other.....

Ethnicity (for national audit purposes).....

Nationality (for national audit purposes)

Does the child have any special communication needs? Yes / No

If yes please give details.....

Please list any **reactions** the child has had to any drugs/medication:.....

.....

Is the child up to date with all of their **immunisations**? Yes / No / Not sure

If you are **not sure** then please bring the child's Red Book in for us to check

If you are registering in the UK for the first time please provide a list of all immunisations the child has had so far.

Next of kin/Parental responsibility:

Please list everyone who has legal parental responsibility for your child:

Name: Relationship to child.....:

Contact Details / Telephone number(s).....

Name: Relationship to child.....:

Contact Details / Telephone number(s).....

(Please note that at least one of the above MUST be registered at The Clays Practice and must be living at the same address as the child)

Past Medical History:

Has the child ever suffered from any important medical illness, operation / admission to hospital?

If so, please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No

Current medication:

Healthcare and medication information may take a while to be transferred to our practice.

Please ensure that if you need a repeat prescription for any of your child's medicines within the next 4 weeks, you should obtain these from your old practice before registering with us at The Clays Practice.

You should be able to ask them to send this prescription electronically to a local pharmacy.

You may be asked to book a medication review with a GP here, before they can issue a prescription for the first time.

Please also allow plenty of time when requesting medication here for the first time

Name of medication	Dosage

If you have a copy of your child's repeat medication/s, please pass it to Reception to copy

Medical Carer Information:

Is the child a young carer? Yes / No

Do they have a carer? Yes / No

If yes, please tell us the name & address of the child's carer / the person the child cares for:

.....

When did the child start caring duties?.....

Can we discuss your child's medical record with their carer?

Yes / No

Summary Care Record (SCR):

The NHS is using an electronic record called the SCR to support patient care. The SCR is a copy of key information from your GP record. It provides authorised healthcare staff with faster, secure access to essential information about your child when they need unplanned care (eg A&E) or when your GP practice is closed.

It will allow for more clinically appropriate action or decisions to be made during consultation with the patient. You can opt out if you wish. **Please tick ONE of the following options:**

I want a (full) Summary Care Record with core and additional information	<input type="checkbox"/>
I want a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	<input type="checkbox"/>
I wish to opt out of the Summary care Record. I understand that if I opt out of the Summary Care Record, health services will not be able to access my essential health records in an emergency.	<input type="checkbox"/>

Record Sharing:

As an informed patient, you can choose to permit or restrict access to the information entered into your health record. Your consent can be changed at any time.

Do you consent to the sharing of data recorded at The Clays with any other organisations that may care for your child?

Yes – Share data with other organisations	<input type="checkbox"/>	No – do not share any data recorded here	<input type="checkbox"/>
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Do you consent to the viewing of data by The Clays that is recorded at other care services that may care for your child?

Yes – Consent given	<input type="checkbox"/>	No – Consent refused	<input type="checkbox"/>
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Please sign below:

I confirm that the information provided is true to the best of my knowledge

Signed on the patient's behalf : **Date:**

Relationship to child:.....

Please ensure all the documents are signed and given to a staff member on Reception

For administration only:

Date form returned to The Clays Practice

Staff member receiving form.....