TO COMPLETE REGISTRATION PLEASE FILL IN THE FOLLOWING FORM

HEALTH CHECK QUESTIONNAIRE

We would be grateful if you would complete the following questions **on behalf of your child**

Would you like to be registered for on line services?
Book appointments, order repeat medication & view any allergies? YES/NO

Child's Name: _____

Date of Birth: _____

Name of Next of Kin &
Contact Telephone No: _____

- Does your child have any allergies? Please List: _____
- Does your child suffer from hay fever? _____
- Does your child suffer from asthma? _____
- Has your child been referred or admitted to hospital, if so please give details

_____

Playcare/School_____

Language spoken _____

Health Visitor_____ Social Worker _____

Ethnic Group _____

Main Spoken Language _____

IMMUNISATION RECORD

	Please tick ✓	***Date if known***
Baby injection 1		
Baby injection 2		
Baby injection 3		
MMR 1st		
MMR 2nd		
Preschool booster		

FOR GP OR NURSE

- Weight Kgs _____ Stones _____ Pounds _____
- Height Cms _____ Feet _____ Inches _____

P.T.O