FOR OFFICE USE ONLY	
Proof of identification	PASSPORT ☐ DRIVING LICENCE ☐ OTHER(please state):
Proof of address	BANK STATEMENT ☐ UTILITY BILL ☐ OTHER(please state):
Checked by:	
Date registered:	

Under 16 registration form – to be filled in by the Parent/Guardian

Your Childs Contact and Demographic Details	
Title: Mr ☐ Miss☐	**Surname:**
DOB:	**Firstname(s):**
NHS no (if known):	**Previous surname:**
Gender: Male ☐ Female ☐	**Town & country of birth:**
Home address:	
Home tel. no (NOT MOBILE):	
Ethnicity: WHITE ☐ BLACK AFRICAN ☐ BLACK CARIBBEAN ☐ INDIAN ☐ PAKISTANI ☐ CHINESE ☐ DECLINE TO STATE☐ OTHER(please state)☐	
Main spoken language:	

Next of Kin Details		
Name	**Relationship**	**Contact tel. no & email address**

To help trace your Childs medical records please fill out the following information as applicable	
Previous address in the UK:	
Previous GP Practice while at previous address given above:	
Patients from abroad	
First UK address where they were registered with a GP (if applicable):	
If previously a UK resident, date left UK:	
Date they first came to the UK:	

Family History					
		Relation			Relation
Coronary Heart Disease	☐		Stroke	☐	
Diabetes	☐		High blood pressure	☐	
Epilepsy	☐		Asthma	☐	
Hypothyroidism	☐		Cancer	☐	
Chronic Obstructive Pulmonary Disease	☐		Serious mental illness	☐	

About Your Child	
Height:	**Weight**:
Known allergies:	
Are they an **unpaid** carer for someone?	Yes ☐ No ☐
Do they have a friend/relative who is their carer?	Yes ☐ No ☐
Please provide their name and address if applicable.	
If your child is on any regular medication please attach a copy of your medication repeat ordering slip from your previous surgery.	

Communication Needs			
We're improving how we communicate with patients. Please indicate below if your child requires information in a different format or need communication support.			
My child is deaf/hard of hearing	☐	My child is blind/visually impaired	☐
My child uses a BSL interpreter	☐	My child needs information in large print format	☐
My child uses communication advocate	☐		
My child lip reads	☐	My child needs information in easy read format	☐
		My child need information in Braille	☐
Other communication needs (please specify):			

Data sharing consent

Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations/providers. The data sharing programmes are designed to improve both the individual care you receive, and to understand the needs of patients as a whole in your area. The data extracted is secure and only accessible to authorised staff.

To opt **OUT** of any of the following data sharing programmes please tick the appropriate box.

Data for research

I do not wish identifiable data about my child to leave the practice. ☐
I do not wish data about my child to be shared by HSCIC. ☐

Summary Care Record

I do not wish my child to have a Summary Care Record. ☐
(Please note this will mean NHS healthcare staff may not be aware of your current medications, any allergies or adverse reactions to previous medication)

Hampshire Health Record

I do not wish my child to have a Hampshire Health Record. ☐

Signature: ..... **Date:** .....