Child Registration Form

Patient Name:…… **D.O.B:……**

Contact Number: ……..

I give explicit consent for the GP Surgery to contact me via text message in regards to my child. Please sign below. *(If you do not wish to give consent please speak to reception)*

Parent / Guardian Signature:…….. **Date**:……

Proof of Identity and Address Provided?

Birth Certificate	Driving Licence	Passport	Utility Bill
Allowance Book	Solicitors Letter	Offer of tenancy	Other

Summary Care Record

Do you wish to opt out? Yes / No
If you do no opt out of having a summary care record one will be created for you by default. If you would like to opt out please ask reception staff for an **OPT-OUT FORM**

Sharing of Medical Data

Care Data Programme - Sharing parts of your GP record with the National Health & Social Care information centre. If you do not wish for your data to be shared in this way please visit https://www.nhs.uk/your-nhs-data-matters/ for more information.

Ethnic Group (please tick as applicable)

White	British / Irish / Other
Black	Caribbean / African / Other
Asian	Indian / Pakistani / Other
Chinese	(Please State)

Mixed	White & Black Caribbean / White & Black African / White & Asian / Other

School

Please give details:
Name of current school:

Parent / Guardian – Consent For Access to Childs Records

Please fill in the below information. This is to give consent for the above named child.

Please inform the surgery of any changes

Name:
Relationship:
Signature:
Address:
Contact Details:

Name:
Relationship:
Signature:
Address:
Contact Details:

Nominated Pharmacy

Please give details of your nominated pharmacy
Name: Address: