

Child/Under 18 Registration Form

Fields marked with an asterisk (*) are compulsory.

Date form completed

When registering your child, please bring in proof of any vaccinations and immunisations to complete the registration process. No proof of their vaccinations and immunisations may cause a delay in registration.

Details of Child/Young Person Being Registered

*Surname

*Forename(s)

*Date of Birth NHS Number

*Sex Assigned at Birth Male Female Other

*Gender Male Female Other

*Address

Postcode

*Phone Mobile

E-mail

Has the child been known by any other names? If yes, please give details:

Yes No

Ethnicity

First Language Religion
Ethnic Origin Place of Birth

School/ Nursery

Name of School/ Nursery
Address

 Postcode

Previous GP

Name of GP
Address

 Postcode

If You Are From Abroad

Previous Address

 Postcode
Date of Arrival in the UK

Details of Child's Main Carer

*Surname

*Forename(s)

Relationship to Child (mother, father, etc.)

Address (if different from above)

Postcode

Contact Details (if different from above)

Phone Mobile

E-mail

Does the Child have contact with the other parent? Yes No

*Surname

*Forename(s)

Address (if different from above)

Postcode

Contact Details (if different from above)

Phone Mobile

E-mail

Safeguarding

*Is the Child subject to a Secure Order? Yes No

*Has the Child been Remanded to Local Authority Care? Yes No

Name of Social Worker (if applicable)

Contact Number for Social Worker (if applicable)

Individual(s) who have parental responsibility (In case of consent)

Are there any other Significant Carers involved in the upbringing of this Child or Young Person (e.g. step-parent, grandparent, foster parent etc.) If yes, please give details:

Yes No

Are there any other services known or involved with the Family or Young Person? (e.g. Social Care, CAMHS). If yes, please give details: Yes No

Does the Child have any disabilities or distinguishing Features? If yes, please give details: Yes No

Medical Information

Please state any Significant Medical History:

Are they on any repeat medication? If yes, please give details: Yes No

Does the child suffer from any allergies? If yes, please give details: Yes No

Is there any significant Family Medical History? (e.g. Asthma, Heart Conditions etc.)

Does the Child or Young Person Smoke? If yes, please give details:

Yes No

Does the Child or Young Person drink alcohol? If yes, please give details:

Yes No

