LEYTON HEALTHCARE
UNDER 5's

Welcome to our Practice. We hope that you will be happy with the care we provide for you. Our aim is to provide you with advice on many health issues and hopefully to keep you in good health.

Please complete as many of the following questions as you can. This information is COMPLETELY CONFIDENTIAL and will help us to provide you with the appropriate medical care for your needs.

Please bring your child's Red Book or Immunisation details to the Practice

SURNAME _____

FORENAMES _____

GENDER: MALE / FEMALE (please circle)

DATE OF BIRTH: _____

ADDRESS _____

_____

_____

POST CODE: _____

E-MAIL ADDRESS: _____

HOME TEL NO:_____

MOBILE TEL NO: _____

WORK TEL NO: _____

MOTHERS NAME: _____

FATHERS NAME: _____

NAME OF SCHOOL ATTENDED:

_____

DOES YOUR CHILD HAVE A DISABILITY / ANY SPECIAL REQUIREMENTS THAT WE NEED TO TAKE INTO ACCOUNT? ☐ YES ☐ NO

IF YES please give details: _____

_____

RELIGION (PLEASE TICK):

☐ None ☐ Christian

☐ Buddhist ☐ Hindu ☐ Jewish

☐ Muslim ☐ Sikh ☐ Other

If OTHER please state: _____

WHAT IS YOUR CHILD'S COUNTRY OF ORIGIN?:

_____

DATE OF ENTRY INTO UK (IF NOT BORN HERE)?

_____

WHAT IS YOUR CHILD'S MAIN SPOKEN LANGUAGE(S)?

_____

ARE THEY A REFUGEE OR AN ASYLUM SEEKER?

☐ YES ☐ NO

Which ethnic group does your child belong to?

White:
- White British ☐
- Irish ☐
- Other White (please specify) ☐ _____

Mixed:
- White & Black Caribbean ☐
- White & Black African ☐
- White & Asian ☐
- Other Mixed (please specify) ☐ _____

Asian / British Asian:
- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Other Asian (please specify) ☐ _____

Black or Black British:
- Caribbean ☐
- African ☐
- Other Black (please specify) _____

Other Ethnic Categories:
- Chinese ☐
- Any other (please specify) ☐ _____

Not Stated: ☐

DOES YOU CHILD HAVE A SUMMARY CARE RECORD?

☐ YES ☐ NO

IF NO – DO YOU WANT YOUR CHILD TO HAVE ONE?

☐ YES ☐ NO ☐ MORE TIME NEEDED

PAST MEDICAL HISTORY (*Please list any serious illness, operations or accident or conditions with dates)*

DATE	TYPE OF OPERATION, ILLNESS, ACCIDENT or CONDITION

CURRENT MEDICATIONS *(Please include any medicines you regularly purchase from the Chemist or other retail outlet)*

NAME OF MEDICATION	*Dosage*	*Strength*

KNOWN ALLERGIES (*Please list any allergic reactions your child may have to drugs / medicines or any other substances.*

TYPE OF ALLERGY	TYPE OF REACTION i.e. *rash / swelling etc*

IMMUNISATIONS:

Please give the dates when your child had the following immunisations:

BCG: _____

Diptheria/Tetanus/Pertussis (whooping cough)/HIB and Polio

1st:_____2nd: _____3rd: _____

Pneumonia

1st:_____2nd: _____3rd: _____

Meningitis C

1st:_____ 2nd: _____

MMR (Measles, mumps, rubella): _____

Pre-school booster: _____

Any other immunisations:

_____

_____

Parent/Guardians Signature: _____DATE: _____
