St Bartholomew's Medical Centre

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Branch Surgery
South Oxford Health Centre
Lake Street | Oxford | OX1 4RP
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Branch Surgery
Oxford Brookes Medical Centre
3rd Floor Colonnade Building | Gipsy Lane Campus | Headington | Oxford | OX3 0BP | T: 01865 483193 | E: medical.centre@brookes.ac.uk

For completion by parent/guardian for a child aged under 12 years

To register with this practice, please complete this questionnaire as fully as possible. It can take some time for your previous medical records to reach us. The information you give in this questionnaire will help us to provide you with good medical care.

PERSONAL DETAILS (Delete as appropriate)			
Surname		Male Female	
Forename(s)		Home Tel:	
Emergency Contact Name		Relationship:	
Work No:		Mobile Tel	
School or Nursery			

HEALTH DETAILS			
Height		Weight	

MEDICAL HISTORY	
Does your child suffer with any medical conditions? *(please specify)*	
Does your child have any allergies? (Delete as appropriate)	Yes No
Allergic to:	Type of Reaction:
Allergic to:	Type of Reaction:
Allergic to:	Type of Reaction

REPEAT MEDICATION	
Is your child on any medicines at present? (Delete as appropriate)	Yes No
If yes, please provide a recent printout (less than two months old) of their medication to Reception and we will arrange for the items to be set up on our clinical system. If you do not have a printout, please ask for a doctor's appointment to discuss this.	

New Patient Questionnaire (Child) – 2

Routine Child Immunisations			
Name:		**D.O.B**	
	Age Usually given	Date Given	Indicate if declined
1st Diphtheria, tetanus, polio and Hib	2 months		
Pneumococcal (PCV)			
Meningococcal B Part 1			
Rotavirus			
2nd Diphtheria, tetanus, pertussis, polio and Hib	3 months		
Meningitis C (Men C)			
Rotavirus			
3rd Diphtheria, tetanus, polio and Hib	4 months		
Pneumococcal (PCV)			
Meningococcal B Part 2			
Hib/Men C (Menitorix)	12-13 months		
1st MMR (Measles, Mumps and Rubella			
Pneumococcal (PCV) Booster			
Meningococcal B Part 3			
2nd MMR	3yrs 4mnths approx		
4th Diphtheria, tetanus, pertussis, polio and Hib (Pre-School booster)			
5th Diphtheria, tetanus			

Non Routine Vaccines							
	Date Given					Clinical Assessment Outcome	
Mantoux Test						Required	Not Required
BCG							
Meningitis C							
Hib Booster (Haemophilus Influenza B)						<u>BCG Criteria Questions</u>	
Hepatitis B	1st	2nd	3rd			• Has the child had a BCG immunisation • Does the child have a parent or grandparent from a country with high rates of TB, who they have regular contact with. • Was the child born or have they ived in a country with high rates of TB for more than a total of three months of their life?	
Neo Natal Hepatitis B	1st	2nd	3rd	4th	5th		
Other Vaccine received/other information							

Please provide copies of your child's immunisation history if possible
COMPLETE IMMUNSATION HISTORIES FOR 0-19 YEARS IS A REQUIREMENT

Ethnicity – (not nationality)					
White	British	Irish	Other white		
Asian	Asian British	Bangladeshi	Indian	Pakistani	Other Asian
Black	Black British	African	Caribbean	Oher black	
Mixed	Asian & White	Asian & Black	Asian & Caribbean	White African	White Caribbean
Other	Chinese	Japanese	Middle Eastern	Other (please state)	

Country of Birth:			
Does your child speak English? (Delete as appropriate)	Yes No	First Language (if not English):	

Appointments – please book the following appointments if applicable	
If your child has asthma	Appointment with Respiratory Nurse
If your child is currently under hospital care	Appointment with GP required

ELECTRONIC PRESCRIPTION SERVICE (EPS)

The Electronic Prescription Service (EPS) is an NHS service. You will not have to visit the GP practice to pick up your paper prescriptions. Instead, your GP will send it electronically to your nominated Pharmacy. Please indicate your preference below:

I would like repeat prescriptions sent electronically to:	Pharmacy Branch
I would prefer to collect repeat prescriptions from the surgery (Delete as appropriate)	Yes No

SMS TEXT MESSAGING CONSENT

I consent to receiving appointment confirmations, reminders and other notices via text messages and will update the Surgery of any changes to my mobile number.

Signature		Date	

EMAIL CONSENT

I consent to receiving appointment confirmations, reminders and other notices via email and will update the Surgery of any changes to my email address.

Signature		Date	

For admin use

Photo ID seen			
Staff name		Date	