South Street Surgery

Registration Questionnaire for children under 5 years of age

This document is intended to be completed by patients to provide basic health information. Please can you fill in and return to reception so we can ensure your medical records are up to date.

Child's Name: ___________________________**Date of Birth**: ____________________

Address: ____

Does your child suffer from any serious medical conditions? If so please state

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ALLERGIES

Please list any allergies ____

Please list all the medication currently taken by your child

1. ____
2. ____
3. ____
4. ____

Please indicate your child's ethnic origin and main spoken language below

White	British ☐	Irish ☐		Any Other White background *please write in*
Mixed	White and Black Caribbean ☐	White and Black African ☐	White and Asian ☐	Any Other Mixed background, *please write in*
Asian or Asian British	Indian ☐	Pakistani ☐	Bangladeshi ☐	Any Other Asian background, *please write in*
Black or Black British	Caribbean ☐	African ☐		Any Other Black background, *please write in*
Other Ethnic Groups	Chinese ☐			Any Other, *please write in*
Not stated	☐			

Main spoken language ____

Signature ____Parent/Guardian*

Print Name ____

Date ____