**Please complete ALL sections on this form in BLOCK CAPITALS and return with the purple GMS1 form, plus baby book or birth certificate as proof of identity**

**Please bring a copy of your child's vaccination book so that we can update the medical record.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TITLE** | Master / Miss | | | | | | |  | | | |  | |
| **DATE OF BIRTH** |  | | | | | | | **ARE YOU:** | | | | **MALE / FEMALE** | |
| **SURNAME** |  | | | | | | | **FORENAME** | | | |  | |
| **ANY PREVIOUS SURNAME(S)** |  | | | | | | | **MIDDLE NAME(S)** | | | |  | |
| **ADDRESS AND POSTCODE** |  | | | | | | | **HOME TELEPHONE**  **MOBILE NUMBER** | | | | | |
| **PLACE OF BIRTH** |  | | | | | | |
|  |  | | | | | | |  | | | | | |
| **ETHNICITY - Please CIRCLE your answer** | | | | | | | | | | | | | |
| White British | | British / Mixed | | | | White & Asian | | | Other White | | | | Other Mixed |
| White & Black African | | Other Black | | | | Indian / British Indian | | | British / British Pakistani | | | | British / British Bangladeshi |
| Chinese | | Other Asian | | | |  | | |  | | | |  |
| **Other – PLEASE STATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **MAIN LANGUAGE SPOKEN** | | | | | | | | | | | Do you require an interpreter? **YES / NO**  If YES, is there a specific dialect needed? | | |
|  | | | |  | | | | | | |  | | |
| Do you give consent for us to send you text messages or emails from the surgery? | | | | | | | | **TEXT**  **YES / NO**  **EMAIL YES / NO** | | | | | |
| Do you give consent for us to share your Summary Care Record with hospitals in an emergency situation? | | | | | | | | **YES / NO** | | | | | |
| **NEXT OF KIN DETAILS** Please provide details of your next of kin. | | | | | | | | | | | | | |
| **NAME** | | |  | | | | | | | **MALE / FEMALE** | | | |
| **CONTACT NUMBER** | | |  | | | | | | | **RELATIONSHIP TO PATIENT** | | | |
| **DO YOU GIVE US PERMISSION TO DISCUSS YOUR CARE WITH THIS PERSON IN AN EMERGENCY?** | | | | | | | | | | **YES / NO** | | | |
| **EMERGENCY CONTACT** Please give details of the person we should contact on your behalf in case of an emergency (if this person is not your next of kin) | | | | | | | | | | | | | |
| **NAME** | | |  | | | | | | | **MALE / FEMALE** | | | |
| **CONTACT NUMBER** | | |  | | | | | | | **RELATIONSHIP TO PATIENT** | | | |
| **DO YOU GIVE US PERMISSION TO DISCUSS YOUR CARE WITH THIS PERSON IN AN EMERGENCY?** | | | | | | | | | | **YES / NO** | | | |
|  | | | | |  | | | | | | | | |
| **IS YOUR CHILD ALLERGIC TO ANYTHING?** | | | | | **YES / NO** | | If yes, please provide details | | | | | | |
|  | | | | | | | | | | | | | |
| Your child will automatically be registered for our Online Services, to enable you to order repeat medications.  The prescriptions will be sent electronically to a pharmacy of your choice. Please let us know which Pharmacy you wish to use **here –**  **MY NOMINATED PHARMACY IS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **IF ANY OF THIS INFORMATION CHANGES IN THE FUTURE PLEASE NOTIFY THE SURGERY, IN WRITING OR BY EMAIL, AS SOON AS POSSIBLE.** | | | | | | | | | | | | | |