|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| FULL NAME: |  | | | | DOB: | \_\_\_/\_\_\_ / \_\_\_\_\_\_ | |
| ADDRESS |  | | | | | | |
| NAME OF MOTHER |  | | | MOBILE NO: | | |  |
| NAME OF FATHER |  | | | MOBILE NO: | | |  |
| HOME NUMBER |  | | | | | | |
| OCCUPATION OF MOTHER: |  | | OCCUPATION OF FATHER: | | | |  |
| **IS THERE ANY FAMILY HISTORY OF:-** | | | | | | | |
| ASTHMA | YES □ / NO □ | | WHO? | | |  | |
| DIABETES | YES □ / NO □ | | WHO? | | |  | |
| CANCER | YES □ / NO □ | | WHO? | | |  | |
| STROKE | YES □ / NO □ | | WHO? | | |  | |
| HEART DISEASE | YES □ / NO □ | | WHO? | | |  | |
|  | | | | | | | |
| **HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS? Please list below** | | | | | | | |
| OPERATION / ILLNESS | | | | | | DATE OF OPERATION / DIAGNOSIS | |
|  | | | | | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ | |
|  | | | | | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ | |
| **DOES YOUR CHILD HAVE ANY CURRENT MEDICAL PROBLEMS?** *Please list below* | | | | | | | |
|  | |  | | | | | |
|  | |  | | | | | |
| **IS YOUR CHILD ON ANY MEDICATION?** *Please list below* | | | | | | | |
|  | |  | | | | | |
|  | |  | | | | | |
| **DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES?** *Please list below* | | | | | | | |
|  | |  | | | | | |
|  | |  | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **IS YOUR CHILD SUBJECT TO A CHILD PROTECTION PLAN OR UNDER THE CARE OF SOCIAL SERVICES?**  *Please ✓ below* | | | | | |
| YES □ NO □ | | | | | |
| **CHILD IMMUNISATION DETAILS:**  *Please ✓ where applicable and provide a date of immunisation* | | | | | |
| DIPTHERIA | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| TETANUS | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| PERTUSSIS  [whooping cough] | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| HIB | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| POLIO | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| MMR | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| RUBELLA | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| PSB  (Pre-school booster) | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| MEN C | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| PNEUMOCOCCAL | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| ROTAVIRUS | YES □ / NO □ | | If “YES”, when? | | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
|  |  | |  | |  |
| **ETHNICITY:** *Please ✓ the appropriate option* | | | | | |
| **White**   * English/Welsh/Scottish/Northern Irish/British * Irish * Gypsy or Irish Traveller * Any other White background, please specify below: | | **Mixed / Multiple ethnic groups**   * White and Black Caribbean * White and Black African * White and Asian * Any other Mixed / Multiple ethnic background, please specify below: | | **Asian / Asian British**   * Indian * Pakistani * Bangladeshi * Chinese * Any other Asian background, please specify below: | |
| **Black / African / Caribbean / Black British**   * African * Caribbean * Any other Black / African / Caribbean background, please specify below: | | | | **Other ethnic group**   * Arab | |