|  |  |  |  |
| --- | --- | --- | --- |
| 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
 |