

POUND HOUSE SURGERY

8 The Green, Wooburn Green, Bucks HP10 0EE
Tel: 01628 530 997 Fax: 01628 521709

Dr Elizabeth Bailey
Dr Kristian Holy

Dr Raj Thakkar

Dr Shareen Hallas
Dr Mia Murray

Child New Patient Questionnaire (under 16)

Today's Date:

Name of Child: Date of Birth.....

Address:.....
.....

Telephone Number(s):

(please note – if a mobile number is given, we will remove this number from the child's records on their 14th birthday in order to comply with our confidentiality policy)

Name of Main Carer Relationship to child:.....

If born since 2003, is father's name on birth certificate? (for consent purposes)...yes / no

School currently attending:

Immunisations:

Please bring your child's red book in at time of registration. If you do not wish your child to be given any immunisations it is important that you inform the practice and sign a disclaimer form. If you wish consent for your child's immunisation to be given by someone other than the child's mother (e.g. if someone other than the mother will bring the child for his/her immunisations, even if this is the child's father) please state the name and relationship to the child below and sign your consent:

Name: Relationship to child

I consent to the above named person bring my child for immunisations and authorise them to give consent for immunisation of my child.

Mother's signature:.....

Print Name.....