Co-operative Medical Care

Patient Registration Form: CHILD

For children under the age of 16 only (young persons aged 16 and over to complete an Adult Registration Form)
Please complete clearly all relevant sections of this registration form.

co-operative medical care

PRIMARY ②

1. Patient Information					
Title:		Gender Identity:	☐ Female ☐ Male ☐ Trans ☐ Other		
Family Name:		Ethnicity: Select A and B	A: ☐ White ☐ Black ☐ Asian ☐ Mixed ☐ Other B: ☐ British ☐ European ☐ Other		
Given Name(s):		Resident Since: Month/Year	/		
Known As:		Date of Birth:			
Previous Family Name:		Jersey SSD No/Card:			Seen By:
Jersey SSD HIF Status: (For Practice to complete)	☐ HIO ☐ HMA ☐ Private	Identification Confirmed: (Passport / Birth Certificate)	☐ Yes ☐ No	ID Type:	Seen By:

2. Address and Parent/Legal Guardian Information (At least one Parent or their Guardian must also be registered with the practice)			
Title:		Relationship to Child:	
Family Name:		Home Address & Post-Code:	
Given Name(s):			
Date of Birth:			
Mobile Telephone:			
Other Parent/Guardian:		Other Parent Mobile:	

3. Medical History

Allergies: Does the child have any known allergies or do they have any adverse reaction to drugs or medication ☐ Yes ☐ No
If Yes please provide details:

Does the child currently take any medication?: ☐ Yes ☐ No
If Yes please provide details:

Does the child suffer from any significant ongoing medical problems?: ☐ Yes ☐ No
If Yes please provide details:

Has the child had any serious illness or operations in the past?: ☐ Yes ☐ No
If Yes please provide details:

4. Immunisation History (IMPORTANT: Please provide copy of Red Book or Immunisation History/Record)

☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 12 Months	☐ 13 Months ☐ 3 Years ☐ 14 Years ☐ HPV	Child's Current School: Child's Health Visitor:

Please provide to the practice any information regarding any other vaccinations given to this child.

5. Private Medical Insurance (The Parent/Guardian is responsible for making all claims with the insurer)	☐
Insurance Provider:	

6. Previous/Existing GP Information			☐
GP Name:		Telephone Number:	
Address:			
Reason for leaving:			

7. Patient Declaration, Confidentiality Agreement, Personal Data Statement and Communication ☐

This declaration should be signed 'for and on behalf of' the child named on this registration form by the Parent/Legal Guardian as given in section 2.

Privacy Policy
Co-operative Medical Care – The Channel Island Co-operative Society Limited
Available on line or hard copy.
www.channelislands.coop/YourRights

General Practice Central Services (GPCS):
All Jersey GP Practices and other approved healthcare service providers, such as the out-of-hours doctors, use a central medical records system known as EMIS. This allows access to a 'shared medical record' to ensure that the provider or clinician has immediate up-to-date and accurate information about your health and any current treatment you may be having. You do however have the right to 'opt out' of sharing some or all of your medical records.

Your Declaration to us:

- I confirm that all the information I have given in this registration form is accurate to the best of my knowledge.
- I understand that the Practice has the right to accept or decline my registration application at any time.
- I understand that by attending a consultation with a GP or other healthcare professional of the Practice, I accept the Practice terms of service and fee schedule issued and displayed in the Practice premises and as amended from time to time.
- I hereby agree to pay any incurred service fees from the Practice at the time of attendance or treatment.
- I expressly consent that on registration or prior to accepting any credit arrangement from the Practice, where appropriate a credit reference check may be taken with an authorised credit reference agency and/or my previous medical practice(s).
- I give my express permission for the Practice to request information including my medical records from my previously registered GP and I agree to reimburse the Practice for any charges and disbursements incurred relating thereto for the Practice being provided with such information.
- I understand it is my sole responsibility to advise the Practice in writing of any changes made in respect of my personal information.
- I have read, understand and accept the Privacy Policy, as amended from time to time.
- I give my express consent for my 'special category' medical, clinical and healthcare related personal data to be collected, processed and shared in accordance with the Privacy Policy.
- I understand I that I will only receive marketing communications if I have expressly consented to receive them by the following methods either now or later. I understand that I do not have to agree to receive marketing communications from the Practice in order receive any medical services. I hereby consent to receiving marketing communications:
  Tick if required
  By letter ○
  By telephone ○
  By SMS text message ○
  By e-mail ○

Child Name:	Date of Birth:	
Signed:	Print Full Name:	Dated:

For Practice Use Only	On EMIS By:	☐ Pre-Registration ☐ Regular ☐ Private	EMIS Number:
Medibooks:	Synchronised:	Billing Pattern:	Alternative Billing Address
Past medical records requested*	Date:	Requested By:	Received Date:
Other GP Informed of Registration:	Date:	Informed By:	Check Requested:

- *Send copy of Page 2 section 7 (signed) to existing GP as authorisation to release medical records to the Practice and amend EMIS patient type*

- *Use separate registration form for visitors or secondary users of the practice..*