Care Quality Commission
Dr N Chandra & Partners
CQC overall rating
Outstanding ☆
4th August 2016

North Road Suite
RAVENSTHORPE HEALTH CENTRE

NHS
Providing NHS services

CHILD REGISTRATION FORM UNDER THE AGE OF 16

Male/Female:	M ( ) F ( )	**Date of birth**	DATE	MONTH	YEAR
Forename(s)					
Surname		**Known as if used**			

Home phone number	
Mobile Number	
Email address	@
Parent or Guardian details: Title, Surname Forename:	Mother ( ) Father ( ) Legal Guardian ( ) other please state:
Relationship to child:	

Childs Height		**Childs Weight**	
Does your child have any Allergies?		**Does your child have any disabilities?**	

Please state your child's ethnicity	
Does your child have any other serious or chronic illness? E.g. Asthma	Please explain
Has your child had any significant injuries or major operations?	If yes, please give details:
Do they take any regular medications?	If possible, attach a copy of your child's repeat prescription list.
Medication name	Dosage / Repeat / Quantity Remaining

PARENT OR GUARDIAN DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	
Date	

Thank you for completing this form.

Please return this form to a member of the patient services team who will make an appointment for your Childs new patient health check.

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