



PARK ROAD GROUP PRACTICE

Patient Health Questionnaire – Child under 16

<input type="checkbox"/> Master <input type="checkbox"/> Miss	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth __/__/____
First Name (s)		Last Name
Please enter your child's Ethnic Origin:		
Please list any known allergies:		
Immunisations If you are from abroad, please provide copies of your child's Immunisation records with your registration form. If you are unable to provide this you will be required to attend a 20 min appointment with a Practice Nurse to discuss your vaccination history and requirements.		
Is your child a looked after child under the care of the local authority?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what capacity? <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent Which local authority? Name of social worker:
Is your child or family currently involved with children's services or have they ever been known to children's services or the safeguarding team?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give further details Name of social worker:
Is your child looking after someone at home? If so, who: Please let us know if your child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems.		<input type="checkbox"/> Yes <input type="checkbox"/> No

Parent/Carer Information	Contact Numbers	Next of Kin	Emergency Contact	Legal Responsibility
Relationship to Patient: Name:	Home: Work: Mobile:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Patient: Name:	Home: Work: Mobile:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Nominated Pharmacy

Please let us know your nominated pharmacy so that your Prescriptions can be sent electronically.

Name of Pharmacy:

Address:

Summary Care Record (SCR)

Our GP Practice supports Summary Care Records. Children will automatically have an SCR made for them. If an Opt Out form is completed, the GP will consider your request.

SCR's contain key information about medicines, allergies and any bad reactions to past medicines. Giving healthcare staff access to this information can prevent mistakes being made when caring for your child in an emergency or when the surgery is closed. To identify your child correctly the SCR will include their Name, Address, Date of Birth and NHS number.

How we use your medical records

The practice handles medical records in-line with General Data Protection Regulations (GDPR). We share medical records with those who are involved in providing you with care and treatment. We share information when the law requires us to do so, for example to prevent infectious diseases from spreading or to check the care being provided to you is safe. Our Data Protection Officer (DPO) is Dr Brooks.

You have the right to be given a copy of your medical record and have any mistakes corrected. You have the right to complain to the Information Commissioner's Office. Please see the Practice privacy notice on the website for further information.

Zero Tolerance Policy

The Practice takes it very seriously if a member of staff is treated in an abusive or violent way. Aggressive behaviour whether violent or abusive will not be tolerated and may result in you being removed from the Practice list and in extreme cases, the Police being contacted.

NHS – National Data Opt-Out

NHS Digital collects information from places where people receive care, such as GP's, hospitals and community services. It is sometimes used for research and planning.

If you do not want your child's personal confidential information shared outside of NHS digital for purposes other than their direct care, you can register to opt out via:

Online registration: <https://www.nhs.uk/your-nhs-data-matters>

By Phone 0300 303 5678

I certify that the information I have provided is correct and consent to my child's personal and medical information being used as stated above.

Your signature:

Date:

Please print name: