

**CHILD (Under 12) MEDICAL QUESTIONNAIRE AND CONTACT PREFERENCES**

**1. Contact information**

Child's full name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M  F

Parents' / Guardians' names  
 (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
 (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Tel: Home \_\_\_\_\_ Work \_\_\_\_\_  
 Mob \_\_\_\_\_ Email address \_\_\_\_\_

**2. Does the child have any allergies to any substances/medications?** Yes  No  If yes, please state below:

Allergy \_\_\_\_\_ Reaction \_\_\_\_\_  
 Allergy \_\_\_\_\_ Reaction \_\_\_\_\_

**3. Is the child taking any regularly prescribed medicines** Yes  No  If yes, please provide a copy of your repeat prescription form from your previous surgery. If unavailable, please list your current medications and doses

Name \_\_\_\_\_ Dose and frequency \_\_\_\_\_  
 Name \_\_\_\_\_ Dose and frequency \_\_\_\_\_  
 Name \_\_\_\_\_ Dose and frequency \_\_\_\_\_

**5. Does the child have any current medical problems requiring ongoing treatment?** Yes  No

a) \_\_\_\_\_ b) \_\_\_\_\_  
 c) \_\_\_\_\_ d) \_\_\_\_\_  
 e) \_\_\_\_\_ f) \_\_\_\_\_

**5. Is there any other health issue you would like us to know about?** Yes  No

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5. Vaccination history** - please state dates given in the boxes below:-

Diphtheria, Tetanus, Pertussis, Polio, Hib, Hep B	1st	2nd	3rd
Diphtheria, Tetanus, Pertussis, Polio, Hib	1st	2nd	3rd
Diphtheria, Tetanus, Pertussis, Polio	Booster		
Pneumococcal	1st	2nd	3rd
Rotavirus	1st	2nd	
Men B	1st	2nd	3rd
Men C	1st	2nd	3rd
Men C / Booster Hib			
MMR	1st	2nd	
Other - please state			

**CONTACT INFORMATION AND CONSENT TO TEXT MESSAGING AND EMAILS**

**Please complete this form and return it to the Practice.**

Contact Name..... Relationship to child.....

Home telephone number..... Mobile number.....

Email address.....

The Practice can contact me by text (please tick) YES  NO

The Practice can contact me by email (please tick) YES  NO

The telephone numbers and/or email address is shared with another person (please specify below)

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Pipeland Medical Practice will keep the contact details of a parent or guardian on a child’s record until the child reaches the age of 12. At this point we will contact the patient seeking up to date contact information or consent to keep the details of a parent or guardian for contact purposes.

If a mobile number or email address is shared with another person, I understand that person will have access to information sent by the practice by text or email, for example appointment reminders.

Signed.....