**Confidential Medical History of Children under 12 Years**

**Admin Staff:** Passport checked if applicable? **YES/NO**

 Please leave completed form in SB’s pigeon hole as soon as completed

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Ethnic Origin** |  | **First Language** |  | **Scanned** |  |
| **Appt date/Time** |  | **Doctor** |  | **Nurse** |  |

|  |  |
| --- | --- |
| **Child’s Name** |  |
| **Child’s Date of Birth** |  |
|  |  |
| **Country of Birth** |  |
| **Mother’s name and Date of Birth** |  |
| **Father’s name and Date of Birth** |  |
| **Course and Length of Course** |  |

**Medical History**

Has the child been diagnosed with any of the following medical conditions?

|  |  |  |
| --- | --- | --- |
|  | **YES/NO** | Date of Onset |
| Asthma |  |  |
| Diabetes |  |  |
| Epilepsy |  |  |
| Any other Medical problems, operations or regular medication? |
| **Allergies**Is your child allergic to anything? To include food items and medication |

|  |
| --- |
| **Vaccination Records** |

**Please complete the immunisation record below with all known dates.**

Childhood vaccines including Tetanus often come in combinations of three or more vaccines.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccines** | **1st** | **2nd** | **3rd** | **4th** | **5th** |
| Tetanus |  |  |  |  |  |
| Diptheria |  |  |  |  |  |
| Pertussis |  |  |  |  |  |
| Polio |  |  |  |  |  |
| HIB (haemophilus influenza type B) |  |  |  |  |  |
| Meningitis B |  |  |  |  |  |
| Meningitis C |  |  |  |  |  |
| Pneumococcal |  |  |  |  |  |
| Rotavirus |  |  |  |  |  |
| MMR (measles/mumps/rubella) |  |  |  |  |  |
| Hib/men C |  |  |  |  |  |
| BCG |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |
| Varicella |  |  |  |  |  |
| Hepatitis A |  |  |  |  |  |

**Vaccinations now due (to be completed by nurse)…………………………………………………………….**

|  |
| --- |
| Which school/nursery does your child attend? |

**Only complete the following if your child is under the age of 5 years:**

|  |
| --- |
| Birth weight |

|  |
| --- |
| Any concerns about development, speech, motor skills or social skills? |

Signature: Date:

Relationship to patient:

Thank you for completing this form