

Northamptonshire Healthcare Foundation Trust

Child Health Record

New Patient Registration Details

PLEASE WRITE CLEARLY AND IN BLOCK LETTERS (ONE FORM PER CHILD)

TRANSFER IN TRANSFER OUT

| CHILD'S CURRENT DETAILS | | CHILD'S PREVIOUS DETAILS | |
|--|-----------------|---------------------------------------|-----------------|
| Surname: | | Surname: | |
| Forename(s) | | Forename(s) | |
| Sex: | D.O.B: | NHS No: | |
| Current Address: | | Previous Address: | |
| Temp/permanent (delete as applicable) | | Temp/permanent (delete as applicable) | |
| Post code: | Tel.No. | Post code: | Tel.No. |
| GP Practice: Name: Address Treatment Centre No: HV Number: | Name of School: | GP Practice: Name: Address | Name of School: |

| PARENT/CARER DETAILS | | | |
|----------------------|--------------|----------------|------------------------|
| Surname: | Forename(s): | Date of birth: | Relationship to child: |
| | | | |

LOOKED AFTER CHILD

ON CHILD PROTECTION PLAN

Please turn over and complete Immunisation details

Immunisation Record

| Routine Childhood immunisations | Age usually given | Date given | Please indicate if declined with reason | | |
|---|-----------------------------|-------------|---|-----------------------------------|---------|
| 1st Diptheria,tetanus,pertussis.polio,Hib Rotavirus | 2 months | | | | |
| Pneumococcal(PCV) Meningitis B (Men B) | | | | | |
| 2nd Diptheria,tetanus,pertussis.polio,Hib Rotavirus | 3 months | | | | |
| 3rd Diptheria,tetanus,pertussis.polio,Hib | 4 months | | | | |
| Pneumococcal(PCV) Meningitis B (Men B) | | | | | |
| Hib/Men C (Menitorix)and | Around 12 months | | | | |
| 1st MMR (measles,Mumps,Rubella) | Around 12 months | | | | |
| 2nd MMR | 3 years 4 months approx | | | | |
| 4th Diptheria,tetanus,pertussis.polio (Pre School Booster) | | | | | |
| Human Papillomavirus vaccine (HPV) From September 2014 2 doses only | Females only 12-18 years | | 1st | 2nd | 3rd |
| 5th Diptheria,tetanus,pertussis.polio (Pre School Booster) | 13-18 years | | | | |
| MenACWY (School Leaver Booster) | 13-18 years | | | | |
| Fluenz | Years 1 2 and 3 | Date Given: | | | |
| Hepatitis B | 1st | 2nd | 3rd | 4th and Blood Test | Booster |
| Evidence of a UK Newborn Blood Spot Test for movers in from abroad | Yes Date Result | No | Test Arranged Yes No | Test Declined Yes Date: | |
| Aged UNDER 2 Neonatal hearing test | Yes Date: | No | | | |

HV/CYPN/PN Name:.....Date:.....

Signature:.....Tel:.....

Please return this form to:

**Child Health
Dryland Block
St Mary's Hospital
London Road
Kettering
NN15 7PW
Or email to Kettering.CH@nhs.net**