

# St Martin Surgery

## PATIENT REGISTRATION FORM:

### CHILD AGED UNDER 16

For children under the age of 16 only (young persons aged 16 and over to complete an Adult Registration Form)

Please complete clearly all relevant sections of this registration form.



ST MARTIN SURGERY

CHILD: PRIMARY ②

1. Patient Information <input type="checkbox"/>			
Title:	Master / Miss /	Gender Identity:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans <input type="checkbox"/> Other
Family Name:		Ethnicity: Select A and B	A: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Mixed <input type="checkbox"/> Other B: <input type="checkbox"/> British <input type="checkbox"/> European <input type="checkbox"/> Other
Given Name(s):		First Language: If not English	
Previous Family Name:		Resident Since: Month/Year	/
Date of Birth:		Jersey SS Health Card No:	Seen By:
Reason For Registering with the Practice:	<input type="checkbox"/> Transferring from another Jersey GP Practice <input type="checkbox"/> Re-Registering with GP Practice <input type="checkbox"/> New Resident In Jersey		
ID Confirmed:	<input type="checkbox"/> Yes <input type="checkbox"/> No	ID Type: (Passport / Driving Licence)	Seen By:

2. Home Address and Parent/Legal Guardian Information (At least one Parent/Legal Guardian must also be primary registered with the practice) <input type="checkbox"/>			
Home Address:		Parent/Legal Guardian Relationship to Child:	
		Parent/Legal Guardian Family Name:	
		Given Name:	
		Date of Birth:	
Post-Code:		Mobile Telephone:	
Other Parent/LG Name:		Other Parent/LG Mobile:	

3. Medical History <input type="checkbox"/>	
<b>Allergies:</b> Does the child have any known allergies or do they have any adverse reaction to drugs or medication <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes please provide details:	
<b>Medication:</b> Does the child currently take any medication?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes please provide details:	
Has child suffered from any significant ongoing medical problems or had any serious illness/operations in the past?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes please provide details:	

4. Child Health Check and Immunisation History (IMPORTANT: Please provide copy of the 'Red Book' or Child Immunisation History Record) <input type="checkbox"/>		
<input type="checkbox"/> 6 Week Baby Check with GP <input type="checkbox"/> First Primary Vaccinations (Aged 8 weeks -13 months) <input type="checkbox"/> Second Primary Vaccinations (Pre-School Aged 3 years, 4months) <input type="checkbox"/> Year 8 School Vaccinations (Aged 12-13) <input type="checkbox"/> Year 9 School Vaccinations (Aged 13-14)	Any Vaccinations Declined: <input type="checkbox"/> Yes (please provide details below)	
	Child's Health Visitor:	
	Child's Current School:	
Please provide to the practice any information regarding declined or any other vaccinations given to this child.		

**5. Private Medical Insurance** (The Parent/Guardian is responsible for making all claims with the insurer)

Insurance Provider:	
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**6. Previous/Existing GP Information** (This will be used to request previous medical record information)

GP Name:		Telephone Number:	
Address:			
Reason for Transferring:			

**7. Patient Declaration, Confidentiality Agreement, Personal Data Statement and Communication**

**This declaration should be signed 'for and on behalf of' the child named on this registration form by the Parent/Legal Guardian as given in section 2.**

**Your Personal Information (Data Protection and Patient Privacy):**  
 The information collected on this application form will be used by St Martin Surgery (hereafter the 'Practice') for the purposes of healthcare related services and practice administration. Personal information we hold about you is processed for the purposes of 'Employment and Social Fields' (Article 8) 'Medical Purposes' (Article 15) and 'Public Health' (Article 16) of the Data Protection (Jersey) Law 2018. This may require your personal data including, relevant details of your medical history, to be shared with other approved healthcare providers for the purpose of referrals and for other lawful purposes related to the Practice procedures. Further information on how we hold and process your data can be found in our Data Protection and Patient Privacy Policy.

**Children Aged 13-16**  
 The Data Protection (Jersey) Law 2018 provides that a child aged between 13 and 16 has their own right to consent and data confidentiality privacy. Therefore if a child aged between 13 and 16 has "sufficient understanding and intelligence to enable them to understand fully what is proposed" (known as Gillick Competence), then they may be competent to give consent for themselves. Further information can be found in our Data Protection and Patient Privacy Policy.

**General Practice Central Services (GPCS):**  
 All Jersey GP Practices and other approved healthcare service providers, such as the out-of-hours doctors, use a central medical records system known as EMIS. This allows access to a 'shared medical record' to ensure that the provider or clinician has immediate up-to-date and accurate information about your health and any current treatment you may be having. You do however have the right to 'opt out' of sharing some or all of your medical records. Please ask us for more information and where appropriate an Opt-in/Out Form for completion. All approved healthcare service providers with authorised access to GPCS have signed strict confidentiality agreements which are bound by the Data Protection (Jersey) Law 2018.

**Your Declaration to us:**

- I confirm that all the information I have given in this registration form is accurate to the best of my knowledge.
- I understand that the Practice has the right to accept or decline my registration application at any time.
- I understand that by attending a consultation with a GP or other healthcare professional of the Practice, I accept the Practice terms of service and fee schedule issued and displayed in the Practice premises and as amended from time to time.
- I hereby agree to pay any incurred service fees from the Practice at the time of attendance or treatment.
- I expressly consent that on registration or prior to accepting any credit arrangement from the Practice, where appropriate a credit reference check may be taken with an authorised credit reference agency and/or my previous medical practice(s).
- I give my express permission for the Practice to request information including my medical records from my previously registered GP and I agree to reimburse the Practice for any charges and disbursements incurred relating thereto for the Practice being provided with such information.
- I understand it is my sole responsibility to advise the Practice in writing of any changes made in respect of my personal information.

Child Name:		Date of Birth:	
Signed:	Parent/Legal Guardian Print Full Name:		Dated:

<b>For Practice Use Only:</b>	EMIS Entered By:	<input type="checkbox"/> Pre-Registration <input type="checkbox"/> Regular <input type="checkbox"/> Private	EMIS Number:
MediBooks:	Synchronised:	Billing Pattern:	Alerts Added:
Past medical records requested*	Date:	Requested By:	Received Date:
Other GP Informed of Registration:	Date:	Informed By:	Check Requested:
Change of Child Demographics:	Date:	Sent By:	
<ul style="list-style-type: none"> <li>• Send copy of Page 2 section 7 (signed) to existing GP as authorisation to release medical records to the Practice and amend EMIS patient type.</li> </ul>			