

**CHILD REGISTRATION FORM**

SURNAME .....FORENAMES.....

ADDRESS.....

.....POSTCODE.....

TELEPHONE NUMBERS HOME..... MOBILE.....

DATE OF BIRTH..... SCHOOL ATTENDED.....

**VACCINATIONS:**

Has your child received the following vaccinations? (Please give dates, if known)

Vaccine	1st Date	2nd Date	3rd Date	Pre-School Booster
Diphtheria Tetanus Whooping Cough Polio HIB				
Men C				
Prevenar				
Measles ) Mumps ) MMR Rubella )				

**ILLNESSES:** Have there been any serious illnesses or hospital admissions/operations?

Please give details.....

**MEDICATION:**

Please give full details of any tablets/medications taken regularly - and the reason for each

**ALLERGIES:** Is your child allergic to anything? Yes  No  Please give details:

**NEXT OF KIN/CARER DETAILS:**