

PLEASE COMPLETE IN BLACK INK

REGISTRATION FORM FOR UNDER 6'S

FULE NAME

ADDRESS

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ETHNIC ORIGIN:

.....

SEX: M/F DATE OF BIRTH: TEL NO:

.....

NAME, ADDRESS OF NEXT OF KIN:

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.....
.....
.

TEL NO:

Immunisation Record

Please ✓

Has your child had all his/her immunisations?

Yes No

Please tick if he/she has had the following immunisations:

Infant Triple: Polio, Meningitis, Hib x 3

Yes No

MMR x 1

Yes No

Pre-school booster (aged 4½)

Yes No

Is there any reason you do not wish your child to have their immunisations?

Yes No

Please comment:

HEALTH HISTORY

Please list any serious illnesses, accidents, operations or disabilities your child has had:

Approx year

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Does your child take any medicines regularly?

If so, please list below:

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