Drs Ryan / McGuinness / McAfee / Donaghey

**CHILD QUESTIONNAIRE** (under 6years)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname | Forename(s)Underline the name by which you are known | TitlePlease circle  | Gender | DOB |
|  |  | Mr / Ms / Mrs / Miss / Dr |  |  |
| AddressIncluding postcode | Main Contact Number | Country of Birth |
|  |  |  |
| Nationality | Consent to being contacted by text? |
|  | Yes / No |
| What is your first language? | Do you require an interpreter? |
|  |  |
| Next of Kin | Contact Number | Relationship to you |
|  |  |  |
| Do you have a Carer?If yes, please give contact details | **Are you registered disabled?**If yes, please give details | Do you have a sensory impairment?If yes, please tick as appropriate |
| Yes / No |  | Hearing Impairment* Deaf
* Partially sighted
* Blind
 |
| List all Medical Conditions | List all Current Medications |
|  |  |
| **Allergies** | **Nominate a chemist for your prescriptions to go to** |
|  |  |

### **IMMUNISATIONS**

|  |  |  |
| --- | --- | --- |
| **Age** | **Vaccine** | **Date Given***(put exact date if possible)* |
| **2 Months** | Diphtheria, Tetanus, Polio, Whooping Cough, Hib, Pneumococcal 1st Rotovirus |  |
| **3 Months** | Diphtheria, Tetanus, Polio, Whooping Cough, Hib, Meningitis C 2nd Rotovirus |  |
| **4 Months** | Diphtheria, Tetanus, Polio, Whooping Cough, Hib, Pneumococcal |  |
| **53 Weeks** | Hib, Meningitis C |  |
| **53 Weeks** | MMR, Pneumococcal |  |
| **3 Years****4 Months** | Diphtheria, Tetanus, Polio, Whooping Cough, MMR |  |

Please delete any not given as this schedule includes some recent additions i.e. Pneumococcal and Meningitis C / Hib Booster.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_