



## Healthplan Application Form – Child 5 yrs/under

If you have obtained a copy of this form online, please fill it in and bring it with you to your child's appointment at The Walcote Practice. Please do not return this form to us by email – we wish to guard your child's medical safety and privacy and therefore we request that you do not send any medical details online. Thank you.

Date form completed:	
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GENERAL INFORMATION			
Title:		First name and middle names:	
Surname:		Town and country of birth:	
Date of birth:		Sex (please circle):	M F
Address (including flat no.):		Who else lives in this household?	
		Name of school or nursery your child attends:	
Adult Name:		Do you consent to allow the Walcote Practice to text you non clinical information and reminders regarding your child to your mobile number? Y N	What is your main language?
Relationship to child:			What is your child's main language?
Home tel no:			
Work tel no:			
Mobile tel no:			
Email address:			
Are you happy to have messages left regarding your child on the following no.s?		Do you or your child require an:	
Home tel no: Y N		- Interpreter? Y N	
Mobile tel no: Y N		- Sign language support? Y N	
		Ethnicity of child:	
		<i>Please see the final page for further information</i>	
As a result of a sensory loss, impairment or disability, do you or your child require information to be presented in any particular format or do you require any support to help us best communicate with you/ your child? Please explain how we can assist ( <i>please see the final page for further information</i> ).			

EMERGENCY CONTACT DETAILS IF THE ADULT ABOVE IS NOT AVAILABLE	
Full name:	Address:
Relationship to child:	
Home tel:	
Mobile tel:	

HOW DID YOU FIND OUT ABOUT/DECIDE TO REGISTER WITH THE WALCOTE PRACTICE? (please tick)		
<input type="checkbox"/> Word of Mouth - from whom (eg a friend)?	<input type="checkbox"/> Advert - where?	<input type="checkbox"/> Other - where?

NHS GP (please also stay registered with your NHS GP in order to access out of hours services)	
GP name:	GP address:
GP tel no:	
Child's NHS number:	

Patient Name:	
Patient Date of Birth:	

IMMUNISATIONS		
NAME	✓	DATE GIVEN
5-in-1 (DTaP/IPV/Hib) vaccine – <b>2 months old</b>		
Pneumococcal (PCV) vaccine – <b>2 months old</b>		
Rotavirus vaccine – <b>2 months old</b>		
5-in-1 (DTaP/IPV/Hib) vaccine (2nd dose) – <b>3 months old</b>		
Meningitis C – <b>3 months old</b>		
Rotavirus vaccine (2nd dose) – <b>3 months old</b>		
5-in-1 (DTaP/IPV/Hib) vaccine (3rd dose) – <b>4 months old</b>		
Pneumococcal (PCV) vaccine (2nd dose) – <b>4 months old</b>		
Hib/Men C booster – <b>12 to 13 months old</b>		
Measles, mumps and rubella vaccine (MMR) – <b>12 to 13 months old</b>		
Pneumococcal (PCV) vaccine (3rd dose) – <b>12 to 13 months old</b>		
Flu vaccine (annual) – <b>2, 3 and 4 years</b>		
Measles, mumps and rubella vaccine (MMR) (2nd dose) – <b>3 years and 4 months, or soon after</b>		
4-in-1 (DTaP/IPV) pre-school booster – <b>3 years and 4 months, or soon after</b>		
HPV vaccine (girls only) – <b>12 to 13 years old</b>		
HPV vaccine (2 <sup>nd</sup> dose, girls only) – <b>12 to 13 years old</b>		
Meningitis C booster – <b>13 to 15 years old</b>		
3-in-1 (Td/IPV) teenage booster – <b>13 to 18 years old</b>		
Meningitis C vaccine for students – <b>18-25 years old</b>		

Please give details of any illnesses, accidents, hospital admissions, investigations or operations your child has had:	
	Date:
	Date:
	Date:
	Date:
	Date:
	Date:
Other ongoing health problems:	
If your child has not had the MMR vaccines as per the schedule above, has your child been vaccinated against measles with a <b>full</b> course of measles vaccines or has your child had the measles virus? Please give details:	
Does your child follow any special diet (eg, low sugar, weight reducing)?	
Does your child have any allergies? If yes, please give details:	

Patient Name:	
Patient Date of Birth:	

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MEDICATION	
Does your child take any regular medication?	Y N
If yes, please state name, dose and number of times per day	
Is your child allergic to any medicines?	Y N
If yes, please state type and name of medicine	

EXERCISE HABIT	
Does your child take regular exercise?	Y N
If yes, what sort?	
For how long at any one time?	
How many times weekly?	

Is there anything else you would like us to know about your child's health?

How can we most help with your child's health?

Is your child known to any other agencies?

FOR PRACTICE USE ONLY					
Date:		Height (cm):		Waist circ (cm):	
Completed by:		Weight (kg):		BP:	
Urinalysis:		BMI:		Blood sugar:	

Patient Name:	
Patient Date of Birth:	

## Summary Fair Processing Notice (Patient Data)

When Walcote Health Ltd (the data controller) processes your/your child's personal data we are required to comply with data protection legislation, including the UK General Data Protection Regulation ('UK GDPR') and the Data Protection Act 2018, to ensure that your/your child's information is properly protected and used appropriately.

Your/your child's personal data includes all the information we hold that identifies you/your child or is about you/your child (eg, your name, address etc). It also includes sensitive information such as your/your child's ethnic origin, medical records etc.

Everything we do with your/your child's personal data counts as processing it, including collecting, storing, amending, transferring and deleting it.

We process your/your child's personal data in order to provide you/your child with the services you have requested, to fulfil the contract we have entered into with you (where applicable), to respond to any queries or comments you/your child submit to us, to correspond with you on a day to day basis and/or to meet legal obligations.

We process most of your/your child's information on the grounds of 'special categories of data processing for the purposes of medical diagnosis and the provision of health care or treatment', although other grounds may at times apply, such as public health.

We only transfer your/your child's personal data to the extent we need to and/or that you request. If you/your child attends our branch surgery at Healthshare Clinic Winchester (HCW), you/your child's name may be shared with HCW for fire safety purposes. Additional personal data may be shared with HCW if you/your child choose/s to be referred to HCW for any further investigations or health consultations. In both of these cases, HCW will act as a data processor. We do not transfer your/your child's personal data outside of the EEA.

As with NHS GP practices, and in accordance with Information Governance Alliance (IGA) guidelines, Walcote Health Ltd will retain your/your child's personal data for a standard period of 100 years after a person's last medical appointment with us. This is in case any queries or issues arise and for health, administrative and/or statutory reasons. Your/your child's information will be kept securely at all times.

You/your child benefit from a number of rights with respect to the personal data we hold about you/your child, depending upon the grounds on which we process your/your child's data and subject to exemptions. These include the right of access to and rectification of your/your child's personal data, the right to restrict or object to data processing, withdraw consent or be forgotten, the right to complain to the Information Commissioner's Office (ICO) and the right to data portability.

Our full Fair Processing Notice provides further details about the personal data we process, why we process it and how we process it. Please ask if you/your child would like to view a copy, or visit [www.thewalcoteppractice.co.uk/useful-documents/](http://www.thewalcoteppractice.co.uk/useful-documents/).

For any queries you/your child may have, please contact our Privacy Officer or any other member of our team in person, by post, by emailing [info@thewalcoteppractice.co.uk](mailto:info@thewalcoteppractice.co.uk) or by calling 01962 828715.

Patient Name:	
Patient Date of Birth:	

**\*\*\*\*Virtual Patient Participation Group\*\*\*\***

Your opinions are very important to us. We have set up a virtual Patient Participation Group and would like to involve a broad spectrum of our patients. Please tick here (and enter your email address on the front page) if you would like to join. This will enable you to help shape our services by answering a question or two sent by the practice infrequently via email.

**Ethnic Group**

Please help us plan for the future healthcare of our population by providing information on your child's ethnicity.

Please insert the ethnicity code corresponding to your ethnic group into the box on the front page of this registration form. Please only use one code. Thank you.

White	British	WBRI
	Irish	WIRI
	Other White background	WOTH
Mixed	White and Black Caribbean	MWBC
	White and Black African	MWBA
	White and Asian	MWAS
	Other Mixed background	MOTH
Asian/Asian British	Indian	AIND
	Pakistani	APKN
	Bangladeshi	ABAN
	Other Asian background	AOTA
Black/Black British	Caribbean	BCRB
	African	BAFR
	Other Black background	BOTH
Other ethnic groups	Chinese	CHNE
	Middle Eastern	MESN
	Other ethnic group (please provide details on front of form if you wish)	OOTH
Decline to provide ethnic group		REFU

**Information & Communication**

We wish to make our services accessible to everyone, so please let us know how we can best communicate with you and your child. Good communication is crucial to healthcare. We do our utmost to provide support to patients with a sensory loss, impairment or disability through the use of:

- communication support
- alternative information formats

For example, we are able to:

- produce documents in large print, easy read or braille formats etc
- use text or email to send information or to book appointments, rather than call by phone, if this is preferable
- offer a portable hearing loop for use during clinic or home visits
- arrange support from an advocate or a communication professional, eg a British Sign Language interpreter