0 – 5 YEARS QUESTIONNAIRE

NAME	
DATE OF BIRTH	
NAMES OF PEOPLE WITH PARENTAL RESPONSIBILITY	

What immunisations has your child had? (please tick appropriate boxes and give dates if possible)

	1st date given	2nd date given	3rd date given
Diphtheria & Tetanus, Polio, Whooping Cough, HIB			
Prevenar			
Meningitis C			
HIB/Men C			
MMR (measles,mumps & rubella)			
Pre school booster			

Has your child had any illnesses/operations?	
Is your child on any medicine/creams/inhalers?	
Has your child had any severe reaction to any previous vaccines? (If so, which and when)	
Any other relevant medical history?	

I would like my ethnic group to be recorded on my records as or I do not wish to have my ethnic group recorded	

Has your child had any problems you would like to discuss? Please feel free to make an appointment with the DOCTOR or HEALTH VISITOR if you wish.

Please complete this form if you have a child under the age of 5

NHS

Requisition for Child Health Record **Nottingham Primary Care Trusts**

May I please request the following record: MCW ☐ HV1 ☐ V and I ☐
(Please tick as applicable)

Forename of child ..... Surname .....

Address .....

Tel No: .....

Date of Birth ..... New GP: Dr S J Bond

Previously living at.....

Previous GP .....

Date ..... Signed ..... Health Visitor
BEESTON HEALTH CENTRE