0-5 YEARS QUESTIONNAIRE

NAME	
DATE OF BIRTH	
NAMES OF PEOPLE WITH PARENTAL RESPONSIBILTY	
What is your main language spoken at home?	

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	

Do you think your child is up-to-date with their immunisations? ☐YES ☐NO

If not, please leave a message at reception for the Health Visitor or Practice Nurse to discuss.

Ethnic Group	I would/would not like my ethnic group to be recorded in my records **(delete as appropriate)** Please record it as:

CHILD VERSION (UNDER 5)