Registration & consent for services Form
Children and Young People

Please do not hesitate to ask the staff to explain this form or for assistance in filling it out.

In an effort to ensure our client details are as accurate as possible, could you please fill out the attached form and return to reception. Updating our system ensures we are always able to contact you if necessary.

Your personal details and/or records are **Private and Confidential** and will only be seen by the appropriate **staff member** within the service **unless** subpoenaed by a court of law or requested under **16A of the Child Care and Protection Act**, in which case we will do our best effort to notify you.

Child / Young person's Details

Full Name: _____ Gender: ☐ Female ☐ Male

Residential Address: _____

Child/Young Person born in Australia: ☐ Yes ☐ No Town of Birth: _____

Date of Birth: _____ Age: _____ Birth Weight (infants only): _____kg

Home Number: Mobile Number: Work Number:

_____ _____ _____

Do you identify as:
☐ Aboriginal ☐ Non-Aboriginal
☐ ATSI connection (?) ☐ Torres Strait Islander
☐ CALD - _____

Medicare Number: _____ REF#: _____ Expiry Date: _____

Health Concession Cards:
☐ Health Care: # _____ Expiry Date: _____
☐ Pensioner: # _____ Expiry date: _____
☐ Senior Health: # _____ Expiry date: _____

Employment Status:
☐ Employed full-time ☐ Employed part-time
☐ Un-employed ☐ Student
☐ Child ☐ Infant

Child / Young person's Details

School that the Child/ Young Person attends: _____

Do you or the child / young person need an interpreter? ☐ Yes ☐ No

Are family law court orders in place? ☐ Yes ☐ No

NOTE: "Emergency Contact" can be different to your "Next of Kin"

Emergency Contact Full Name: _____

Relationship: (mother, father, sister, aunty etc) _____

Emergency Contact Address: _____

Best Contact Number: _____

Next of Kin Full Name: _____

Relationship: (mother, father, sister, aunty etc) _____

Next of Kin Address: _____

Best Contact Number: _____

Is there any other person who would normally come to your appointments on a regular basis, such as a carer or family member? (3RD Party Policy) ☐ Yes ☐ No

Additional Support Full Name: _____

Relationship: (mother, father, sister, aunty etc) _____

Additional Support Address: _____

Best Contact Number: _____

Other Child / Young Person COMPULSORY questions required to be completed

1. Is the child/ young person a smoker? - (Not applicable child under 14yrs) ☐ Yes ☐ No
2. Do they consume Alcohol? - (Not applicable child under 14yrs) ☐ Yes ☐ No
   If Yes, How many per week: _____ Standard Drinks per/ day: _____
3. Does the child/young person have any disabilities? ☐ Yes ☐ No
   Details:
   _____
   _____

Other Child / Young Person COMPULSORY questions required to be completed

4. Do they have any previous medical issues and or conditions? ☐ Yes ☐ No
Details:

_____

_____

_____

5. Is the child/young person on any medications? ☐ Yes ☐ No
Details:

_____

_____

_____

6. Does the child/young person have any allergies? ☐ Yes ☐ No
Details:

_____

_____

_____

7. Do you consent, on behalf of the child/ young person to having follow up letters or phone calls regarding your health and any future appointments? ☐ Yes ☐ No

8. Who is the child/young person's usual or previous GP: _____

9. Would you like to request for your medical records to be transferred from a previous practice? ☐ Yes ☐ No
If Yes - Practice Name: _____ GP Name: _____

Photo Permission for programs ~ Please fill this section out

10. Do you give permission for Waminda to take your child's photo for promotion and use in Publications? ☐ Yes ☐ No

DISCLAIMER

The legal age of consent to medical treatment is 14yrs of age. This is outlined in the (Property and Contracts) Act 1970 (NSW),

The legal age of consent to be case managed and to make decision about your own decisions is 16yrs of age. This is outlined in the Crimes Act 1990 section 66c.

Other Child / Young Person COMPULSORY questions required to be completed

Declaration by Client/Patient

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information. Waminda's Patient Health Information and Collection Use Poster located in our waiting room also provide information of how we will use your personal information.

As a patient of our service, we require you to provide us with the child/ young persons personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in the child's health care needs. The Child's Personal Health File will be accessed ONLY by other employees who may be involved in your care or providing a service.

I have read and understood this Patient Registration Form and agree to it's intended purposes. I am aware of the responsibilities of Waminda and myself in relation to the service/s I shall receive and any information I share with the practice, which is stored electronically using the Communicare. The above information is true and correct at the time of completing this form.

I am aware if I have a conflict with any Waminda staff I have the right to complete a Conflict of Interest declaration form provided by reception.

Please note the person's name who is providing this permission, sign and date.

_____ _____ _____

Full Name Signature Date

Best Contact #: _____

Office Use - ADMIN STAFF to complete

☐ All Details are entered in Communicare Date Entered: _____

Name of Staff (Print): _____ Signature: _____