

Appendix 3



**Pharmacy First For Children
Confirmation of Registration**

Please complete one form per patient (if more than one family member presents at the same time a separate form must be completed for each family member).

Patients name	
Address	
Date of Birth	
NHS number if available	
Parent/Guardian Signature	
Relation to patient	

This person is a patient of this practice and can be accepted onto the Pharmacy First For Children, Minor Ailments Scheme.

SignedDoctor / Nurse / Receptionist/ Pharmacist

Date

Surgery or Pharmacy Stamp

To be retained by the registering pharmacy for a minimum of 2 years