Exemption/Consultation Form
TO BE KEPT AT THE PHARMACY FOR AUDIT PURPOSES

The patient does not have to pay because he/she:

A			**is under 16 years of age**
B			**is 16, 17 or 18 and in full-time education**
C			**is 60 years of age or over**
D			**has a valid maternity exemption certificate**
E			**has a valid medical exemption certificate**
F			**has a valid prescription prepayment certificate**
G			**has a valid war pension exemption certificate**
L			**is named on a current HC2 charges certificate**
X			**was prescribed free-of-charge contraceptives**
H			***gets income support (IS)**
K			***gets income-based jobseekers allowance (JSA (IB)**
M			***is entitled to or named on a valid NHS Tax Credit exemption certificate**
S			***has a partner who gets Pension Credit guarantee credit (PCGC)**

***Name**	**Date of Birth:**	**NI no:**

*Print the name of the person (either you or your partner) who gets IS, JSA (IB), PCGC or Tax Credit

To the Patient - Please complete declaration:-

I have consulted the pharmacist under the Minor Ailments Scheme and confirm that I am exempt from prescription charges for the reason specified above.

I confirm that:
I have received advice and I have / have not (delete as appropriate) **received a supply of medication from the pharmacist under the Minor Ailments Scheme**

I declare that the information I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption. To enable the NHS to check I have a valid exemption and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form to and by NHS England, the NHS Counter Fraud and Security Management Service, the Department for Work and Pensions and Local Authorities.

Signed Patient)…..... Date.....

IMPORTANT – Your Pharmacist is providing treatment and/or advice under the Minor Ailments Scheme in line with the symptoms you have described. If your symptoms persist you should seek further advice from your doctor. Please advise the doctor which pharmacy you have attended and what advice and/or treatment you have already received from the Pharmacist. By signing this form you are giving permission for your pharmacist to:

1. **Make a written note of personal information relating to your health.**
2. **Share information about your health and any medication supplied with your GP and NHS England as necessary.**

Evidence of Exemption Seen: YES / NO(delete as appropriate)

Signed Patient .....…….. Signed Pharmacist .....……..

Exemption/Consultation form (continued). To be completed by the pharmacist
TO BE KEPT AT THE PHARMACY FOR AUDIT PURPOSES

Patient Details ***(Affix bag label or enter details*****)**

Patient name ----------

Address ----------

G P Practice ----------

Would the patient usually have consulted with their GP for this ailment?
Yes / No* (*please delete as appropriate)

Patients Presenting Symptoms (please tick)

Acute Diarrhoea and Vomiting		**Indigestion**	
Allergy		**Mouth Ulcer and Teething**	
Allergic Skin Conditions		**Nappy Rash**	
Bacterial Conjunctivitis		**Oral Thrush**	
Chickenpox		**Pain / Fever**	
Constipation		**Threadworm Infection**	
Cough and Nasal Congestion		**Vaginal Candidiasis**	
Fungal Infections		**Warts / Verrucas**	
Head Lice			

Details of product supplied or action taken (advice or referral* please tick)

Medication Supplied – ***affix Rx label***	
Advice only*	
Referral*	

Signed (Pharmacist): ……Date……..