



CONSENT FORM FOR DELIVERY OF PRESCRIPTIONS TO COCKBURNSPATH

I
(Name) (Date of birth)

Consent / do not consent to my prescription items being delivered to the Cockburnspath shop for collection.

I will collect the medication personally.

If I am unable to collect it in person, I give permission for the following person(s) to collect the prescription on my behalf:-

	1 st Nominated Person	2 nd Nominated Person
Name		
Address		
Postcode		

.....
Signed

.....
Date

PLEASE PRINT AND COMPLETE THIS FORM. IT SHOULD BE HANDED INTO THE COLDINGHAM SURGERY FOR RECORDING BEFORE ANY PRESCRIPTION ITEMS CAN BE DELIVERED TO THE SHOP AT COCKBURNSPATH