MEDICATION REQUEST FORM

COMPLETE THESE STEPS

1. **Please print and complete entire form.**
2. **Attach all prescription(s). You do not need a prescription for over-the-counter requests.**
3. **Attach a copy (front and back) of your insurance card OR PHARMACY BENEFITS CARD if you have one.**
4. **Mail to: kidsMEDPACKS, PO Box 568, Scarsdale, NY 10583.**

Camper Name: ______________________________

Parent/Guardian Name: ______________________________

Home Phone Number: ______________________________

Cell Phone Number: ______________________________

Email Address: ______________________________

Camp Facility: ______________________________

Camp Session Dates: start: __________ end: ______________

Camper DOB (mm/dd/yy): ______________________________

Medication Allergies? Please list: ______________________________

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PLEASE NOTE: BE CAREFUL - Prescription medications will be dispensed EXACTLY as written.

CAREFULLY REVIEW all prescriptions you are submitting. They must be IDENTICAL to your request below.

Medications prescribed to be taken DAILY will be administered at BREAKFAST unless otherwise noted.

LIST ALL MEDICATIONS YOU REQUEST BE FILLED BY kidsMEDPACKS' PHARMACY:

**Please use more than one form if needed for additional medications.*

MEDICATION/VITAMIN *(Prescription and over-the-counter)*	STRENGTH *(ie: mg, ml, mcg)*	DOSAGE FORM *(ie: capsule, liquid, chewable)*	DISPENSING INSTRUCTIONS FOR NURSE *(Please check all that apply)*
			❏ Daily **OR** ❏ Only When Needed **Time:** ❏ Breakfast ❏ Lunch ❏ Dinner ❏ Bedtime ❏ Other Time:_______
			❏ Daily **OR** ❏ Only When Needed **Time:** ❏ Breakfast ❏ Lunch ❏ Dinner ❏ Bedtime ❏ Other Time:_______
			❏ Daily **OR** ❏ Only When Needed **Time:** ❏ Breakfast ❏ Lunch ❏ Dinner ❏ Bedtime ❏ Other Time:_______
			❏ Daily **OR** ❏ Only When Needed **Time:** ❏ Breakfast ❏ Lunch ❏ Dinner ❏ Bedtime ❏ Other Time:_______

ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS WILL BE DISPENSED EXACTLY AS WRITTEN BY YOUR PHYSICIAN. PLEASE CHECK YOUR DOCTOR'S PRESCRIPTIONS AND YOUR REQUESTS ON THIS FORM CAREFULLY BEFORE SENDING TO KidsMEDPACKS.

*Our partner pharmacy will charge your credit card for any co-payment due or over-the-counter medications supplied. Pharmacy charges may appear on your credit card statement up to two months **after** your camper returns home. Please notify us if your credit card information changes during the summer.*

I acknowledge responsibility for the cost of any medicine not covered by my insurance company, for any medication the pharmacy cannot get reimbursed for, as well as any co-payments and deductibles, which I agree will be billed directly to my credit card by the pharmacy. I agree to authorize the pharmacy to contact my insurance company for insurance verification, billing and collections for my child's medications. Our licensed pharmacy is HIPAA compliant and all personal information received will be solely maintained for the purposes of dispensing prescriptions and insurance collection.

BEFORE YOUR SEND:

❏ Is a copy of your insurance/pharmacy benefits card attached?

❏ Did you check your prescriptions and are they IDENTICAL to your written request?

Signature of Guarantor:____