



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 PHARMACY BENEFITS INSURANCE CARD.
Note: This may be the same card or a different card than your medical insurance card.
- 4 Mail to: kidsMEDPACKS, PO Box 568, Scarsdale, NY 10583.

Camper Name: _____ Camp Facility: _____

Parent/Guardian Name: _____ Camper Session Dates: start: _____ end: _____

Home Phone Number: _____ Camper DOB (mm/dd/yy): _____

Cell Phone Number: _____ Medication Allergies? Please list: _____

Email Address: _____

PLEASE NOTE: Prescriptions will be dispensed **EXACTLY** as written by the prescriber on the prescriptions. **CAREFULLY REVIEW** all written prescriptions to ensure they are **IDENTICAL** to your requests below. IF NOT, contact physician for new prescriptions prior to sending to kidsMEDPACKS.

Medications are dispensed as **GENERICS** unless the **PRESCRIPTIONS** clearly instruct dispensing of "BRAND ONLY" for prescription medications or you write "BRAND ONLY" below for over-the-counter products you are requesting.

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

**Please use more than one form if needed for additional medications. Medications prescribed to be taken DAILY will be administered at BREAKFAST unless otherwise noted.*

MEDICATION/VITAMIN <i>(Prescription and over-the-counter)</i>	STRENGTH <i>(ie: mg, ml, mcg)</i>	FORM <i>(pill, liq, chew)</i>	DIRECTIONS	FREQUENCY	ADMIN TIME
Ex. Medication	10mg	pill	take 1	<input checked="" type="checkbox"/> Daily OR <input type="checkbox"/> Only As Needed	<input checked="" type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime
				<input type="checkbox"/> Daily OR <input type="checkbox"/> Only As Needed	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime
				<input type="checkbox"/> Daily OR <input type="checkbox"/> Only As Needed	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime
				<input type="checkbox"/> Daily OR <input type="checkbox"/> Only As Needed	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime

All **DAILY** medications/vitamins will be automatically refilled if camper session is longer than 30 days.

All **AS NEEDED** medications/vitamins will be refilled **ONLY** when requested by camp nurse.

*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.

- Is a copy of your pharmacy benefits insurance card attached?
- Did you verify that all prescriptions are **IDENTICAL** to your written requests?

Signature of Guarantor: _____