Camper Medication Form

HAYAT PHARMACY

PLEASE FILL OUT FORM EVEN IF A CHANGE IS ANTICIPATED

Do you anticipate a change in any of the medications listed below before Camp starts? YES NO

If, yes please explain:

Camper First Name: Camper Last Name:

Camper Date of Birth: / / Camper Cell Phone Number: ( )

Camper Street Address, City, State, Zip:

Parent/Guardian Full Name:

Parent/Guardian Phone #: ( ) Parent/Guardian Email:

Dates of Camp Attendance (which session/s):

Insurance Information: Please complete the following using your prescription drug card (not your medical insurance card). Or, submit a photocopy of the front and back of your prescription insurance card, along with this form.

Insurance Carrier:

RX BIN: RX PCN: RX GRP:

RX Member ID: Pharmacy Help Desk Phone Number (*usually listed on back of card*): ( )

Please list all medications and over-the-counter medications or supplements.

NOTE: If there are more medications than lines provided, please attach a second page

Prescription Medication Name/ Over-the-Counter Medication*	**Strength**	**Medication Directions**	**Time Taken**	**Prescriber Name and Phone Number**
			☐ Morning (7:30-9am) ☐ Noon (12:30-1pm) ☐ Evening (6-6:30pm) ☐ Bedtime (8:30-9:45 pm)	
			☐ Morning (7:30-9am) ☐ Noon (12:30-1pm) ☐ Evening (6-6:30pm) ☐ Bedtime (8:30-9:45 pm)	
			☐ Morning (7:30-9am) ☐ Noon (12:30-1pm) ☐ Evening (6-6:30pm) ☐ Bedtime (8:30-9:45 pm)	

THERE IS AN ADDITIONAL $10 REPACKAGING FEE FOR EACH MEDICATION THAT IS NOT FILLED BY HAYAT PHARMACY*

IF NO PRESCRIPTION MEDICATIONS ARE BEING PACKAGED (ONLY OTC) THERE WILL BE A $49 PACKAGING FEE APPLIED TO THE TOTAL*

CREDIT CARD INFORMATION: (Total Amount due will be charged 7 days prior to Camp Session starting)

16 DIGIT:_____ EXP DATE: ____/____ CVC:_____ BILLING ZIP:_____

By completing the insurance information above, I agree to authorize Hayat Pharmacy to contact my insurance company for insurance verification, billing and collections for my child's medication. I authorize Hayat Pharmacy to charge my credit card for the total amount due for packaging and copayments. Our licensed Pharmacy is HIPAA compliant and all personal information received will be solely maintained for the purpose of filling prescriptions and processing insurance claims.

Parent/Guardian Printed Name: Date:

Parent/Guardian Signature: