My Camper's Medication ***Has Changed***

IF MORE THAN ONE CHILD IS ATTENDING CAMP, PLEASE COMPLETE A SEPARATE FORM FOR EACH CAMPER. IF YOU HAVE QUESTIONS, CALL US AT 1 (951) 407-0707.

LIST ALL the medications your camper will be taking at camp, since this form will invalidate the previous form you submitted. In this form, you will also have the option to enter insurance information if your insurance has changed. Make sure either you, or your physician send all prescriptions to Perris Hills Pharmacy.

PARENT OR LEGAL GUARDIAN INFO

FIRST NAME: | LAST NAME: | HOME NUMBER:

MOBILE NUMBER: | EMAIL:

MY CAMPER'S INFO - The information of the child going to camp.

FIRST NAME: | LAST NAME: | DATE OF BIRTH, MM / DD / YYYY:

MY CAMPER'S MEDICATIONS - Please list all medications (prescription, OTC, vitamins and supplements) that the camper is currently prescribed or is taking.

FOR EACH MEDICATION:

IF PRESCRIBING PHYSICIAN IS THE CAMPERS PRIMARY PHYSICIAN, CHECK THE BOX THAT SAYS "SAME AS PRIMARY."
(PRIMARY PHYSICIAN WAS GIVEN IN THE PREVIOUS FORM)

IF PRESCRIBING PHYSICIAN IS DIFFERENT THAN YOUR CAMPERS PRIMARY PHYSICIAN, ENTER PHYSICIAN'S NAME, PHONE AND FAX.

	MEDICATION NAME: (Ex: Albuterol)	**ADMINISTRATION TIME:** (Breakfast, Lunch, Dinner, Bedtime or As Needed/PRN)	**DOSAGE:** (Ex: 200 mg)
EXAMPLE	Albuterol	Breakfast and Dinner	4 mg
	DIRECTIONS: To be taken at the same times each day		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME: Lisa Cuddy	PHONE #: 1 (951) 501 4401 / FAX #: 1 (951) 501 4444
1			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: / FAX #:
2			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: / FAX #:
3			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: / FAX #:

	MEDICATION NAME: (Ex: Albuterol)	**ADMINISTRATION TIME:** (Breakfast, Lunch, Dinner, Bedtime or As Needed/PRN)	**DOSAGE:** (Ex: 200 mg)
4			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
5			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
6			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
7			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
8			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
9			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
10			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
11			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
12			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:
13			
	DIRECTIONS:		
	PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY	PHYSICIAN NAME:	PHONE #: FAX #:

HAS YOUR INSURANCE ALSO CHANGED? ☐ YES ☐ NO If Yes, please enter information.

IF YOU HAVE A PRIMARY AND SECONDARY INSURANCE, MAKE SURE TO ADD BOTH.

PLEASE BE AWARE, IN THE CASE YOUR NEW INSURANCE DENIES THE CHARGES, WE RESERVE THE RIGHT TO CHARGE YOUR CREDIT CARD FOR THE FULL COST OF MEDICATION. ALL CREDIT CARD CHARGES FROM THE PERRIS HILLS PHARMACY WILL APPEAR AS A SEPARATE CHARGE AFTER YOUR CHILD RETURNS FROM CAMP.

PRIMARY INSURANCE

INSURED NAME: INSURANCE NAME:

INSURANCE PHONE #: MEMBER ID:

RX BIN: RX PCN: RX GROUP:

SECONDARY INSURANCE

INSURED NAME: INSURANCE NAME:

INSURANCE PHONE #: MEMBER ID:

RX BIN: RX PCN: RX GROUP:

I Acknowledge And Understand The Following:

1. A LATE FEE OF $25.00 WILL BE CHARGED IF MY CAMPER'S REGISTRATION IS NOT RECEIVED BY PERRIS HILLS PHARMACY AT LEAST 30 DAYS PRIOR TO THE START OF CAMP SESSION.
2. AN ADDITIONAL $30.00 EXPEDITED SHIPPING FEE WILL BE CHARGED IF PRESCRIPTIONS NEED TO BE "RUSHED" TO THE CAMP BEFORE THE BEGINNING OF YOUR CAMPER'S SESSION.
3. ALL CONTROLLED DRUG PRESCRIPTIONS SHOULD BE WRITTEN OUT FOR UP TO 30 DAYS SUPPLY ONLY. IF YOUR CHILD IS ATTENDING CAMP FOR MORE THAN 30 DAYS, A SEPARATE PRESCRIPTION IS REQUIRED FOR EACH 30 DAY PERIOD.
4. "DO NOT FILL BEFORE" DATE ON CONTROLLED DRUG PRESCRIPTIONS SHOULD BE 2 WEEKS PRIOR TO START OF CAMP SESSION.
5. ALL OTC'S REQUIRE A PRESCRIPTION WRITTEN BY YOUR CHILD'S PHYSICIAN.
6. ALL PRESCRIPTIONS SHOULD BE WRITTEN FOR THE TIME OF DAY THE MEDICINE IS TO BE ADMINISTERED TO THE CAMPER (BREAKFAST, LUNCH, DINNER, BEDTIME). IF THE MEDICINE IS TAKEN "AS NEEDED" PLEASE MAKE SURE IT IS SPECIFIED IN THE PRESCRIPTION.
7. ALL PRESCRIPTIONS WILL BE FILLED GENERICALLY (IF AVAILABLE) UNLESS OTHERWISE SPECIFIED BY YOUR CHILD'S PHYSICIAN AS "DO NOT SUBSTITUTE."
8. ALL PRESCRIBED MEDICATIONS AND OTC MEDICATIONS MUST BE DISTRIBUTED BY THE PHARMACY, DO NOT SEND ANY MEDICATIONS TO THE PHARMACY, CONTACT THE PHARMACY IF YOU HAVE QUESTIONS OR CONCERNS.
9. I AGREE TO PERRIS HILLS PHARMACY'S TERMS OF USE AND PRIVACY POLICY AGREEMENT.

TODAY'S DATE MM / DD / YYYY

PARENT/GUARDIAN SIGNATURE

Thank you for entrusting us with you camper's medication!

Fax this form to: 1(844) 856-8900

PERRIS HILLS PHARMACY
TAKING CARE OF PEOPLE FIRST

Phone: 1 (951) 407-0707 **Fax:** 1 (844) 856-8900
524 W 4th Street, Suite A • Perris, CA 92570
Camp@PerrisHillsPharmacy.com
PerrisHillsPharmacy.com

my kiDs CAMP meds