# *Camper Medication Form*

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.

**We strongly encourage** any liquid medications to be exchanged for oral disintegrating tablets (ODT) or chewables, this will help ensure proper administration of the medication. Liquid medication can easily spill and is difficult to safely carry while in outdoor excursions.

**Please you review** your camper's Rx with your physician to confirm it is written exactly the way your camper takes the medication before sending to Perris Hills Pharmacy.

## PARENT OR LEGAL GUARDIAN INFO

FIRST NAME: LAST NAME: HOME NUMBER:

MOBILE NUMBER: EMAIL:

ADDRESS: CITY: STATE: ZIP CODE:

## SECONDARY PARENT OR LEGAL GUARDIAN INFO - Due to HIPAA regulation list any other person that can have access to your campers information. Perris Hills Pharmacy will only be able to discuss medication info with persons noted on this form.

FIRST NAME: LAST NAME: HOME NUMBER:

MOBILE NUMBER: EMAIL:

## INSURANCE INFORMATION - Please leave fields blank that do not apply.

### 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:

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

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

GENDER: | LIST ALL DRUG ALLERGIES:

LIST ALL OTHER ALLERGIES: Food, seasonal, etc

LIST ALL CHRONIC ILLNESSES:

## CAMPER'S PROGRAM - Which program has your camper registered for?:

CAMP PROGRAM NAME: | CAMP SESSION NAME:

FIRST DAY OF CAMP, MM / DD / YYYY: | LAST DAY OF CAMP, MM / DD / YYYY:

## PRIMARY PHYSICIAN'S INFORMATION

FIRST NAME: | LAST NAME: | OFFICE PHONE #:

OFFICE FAX #: | EMAIL:

## MY CAMPER'S MEDICATIONS - Please list all medications (prescription, OTC, vitamins and supplements) that the camper is currently prescribed or is taking. We understand that this list might change as we approach camp season.

**FOR EACH MEDICATION:**

**IF PRESCRIBING PHYSICIAN IS THE CAMPERS PRIMARY PHYSICIAN,** CHECK THE BOX THAT SAYS "SAME AS PRIMARY."

**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: Gregory House — PHONE #: 1 (951) 501 4401 — FAX #: 1 (951) 501 4444 | | |
| 1 | | | |
| | 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) |
|---|---|---|---|
| **2** | | | |
| | DIRECTIONS: | | |
| | PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY | PHYSICIAN NAME: | PHONE #: FAX #: |
| **3** | | | |
| | DIRECTIONS: | | |
| | PRESCRIBING PHYSICIAN: ☐ SAME AS PRIMARY | PHYSICIAN NAME: | PHONE #: FAX #: |
| **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 #: |

## PARENT/GUARDIAN PAYMENT AUTHORIZATION - Credit Card will be charged after filling Prescription.

NAME ON CREDIT CARD

BILLING ADDRESS: CITY: STATE: ZIP CODE:

CARD NUMBER: TYPE OF CARD:

EXPIRATION DATE: SECURITY CODE: VISA, MASTERCARD, DISCOVER, ETC: Back of card, the last 3-digits printed
AMERICAN EXPRESS: Front of card, the 4-digits printed above the credit card's number

I acknowledge and assume responsibility and grant authorization for Perris Hills Pharmacy and/or its parent company or affiliates to charge the above credit card for the cost of any medication not covered by my insurance company, for any medication that Perris Hills Pharmacy cannot get reimbursement for, as well as any co-pays and deductibles and charges for OTC/Sundries which I agree will be billed to my credit card by Perris Hills Pharmacy. I authorize Perris Hills Pharmacy to contact my insurance company for verification of coverage, billing, and collections for my medications. As per our HIPAA agreement, all personal information received will be solely maintained for the purposes of dispensing prescriptions and insurance collection

TODAY'S DATE MM / DD / YYYY

PARENT/GUARDIAN SIGNATURE

## *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