CampPacks

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: CampPacks, 1081 Main St. PO Box 458, Schroon Lake, New York 12870

Camper Name:_____
Parent/Guardian Name:_____
Home Phone Number:_____
Cell Phone Number:_____
Email Address:_____

Camp Facility:_____
Camper Session Dates: start:_____end:_____
Camper DOB (mm/dd/yy):_____
Medication Allergies? Please list:_____
_____

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 request below. **IF NOT**, contact physician for new prescriptions prior to sending CampPacks.

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

LIST ALL MEDICATIONS YOU REQUEST BE FILLED BY CampPacks 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 *(Prescription and over-the-counter)*	**STRENGTH** *(ie: mg, ml, mcg)*	**FORM** *(pill, liq, chew)*	**DIRECTIONS**	**FREQUENCY**	**ADMIN TIME**
Ex. Medication	10 mg	pill	take 1	☑ Daily **OR** ☐ Only As Needed	☑ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime
				☐ Daily **OR** ☐ Only As Needed	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime
				☐ Daily **OR** ☐ Only As Needed	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime
				☐ Daily **OR** ☐ Only As Needed	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime
				☐ Daily **OR** ☐ Only As Needed	☐ Breakfast ☐ Lunch ☐ Dinner ☐ 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 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 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 purpose 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 request?

Signature of Guarantor:_____