STEPHENS PHARMACY CAMPER PRESCRIPTION FORM

NAME OF CAMP ______________________________ PHONE ________________

PATIENT NAME ______________________________ DOB ________________

HOME ADDRESS ______________________________

HOME PHONE ______________________________

PARENT NAME ______________________________

RX REQUESTED

NAME OF RX ______________________________

QUANTITY ______________________________

DIRECTIONS TO TAKE/USE RX ______________________________

____

CAMP DR REQUESTING RX ______________________________
DOES THE CAMPER HAVE ANY ALLERGIES TO MEDICATIONS?
YES ________ NO ________ IF YES WHAT ______________________________

QUESTIONS OR COMMENTS FOR PHARMACY

____

PT PHARMACY INSURANCE INFO (NOT MAJOR MED INFO)
INSURANCE CO NAME AND PHONE NUMBER

____

INSURANCE BIN # ______________________________ PCN# ________________

ID # ______________________________ GROUP # ________________

CARDHOLDER NAME ______________________________

IF TO BE CHARGED TO CC COMPLETE THE INFO BELOW OTHERWISE THE COPAY/FEES WILL BE CHARGED TO THE CAMP

CARD TYPE ______________ CARD NUMBER ______________________________

EXPIRATION DATE ______________ NAME ON CARD ______________________________

FAX TO PHARMACY 251-7809 OR DME 253-7361