IMPORTANT - MAIL THIS FORM TO KEYSTONE PHARMACY ALONG WITH REGISTRATION RECEIPT, PRESCRIPTIONS AND PRESCRIPTION COVERAGE CARD (if applicable)

Keystone Professional Pharmacy

485 S. River St., Wilkes-Barre, PA 18703 phone 570-970-2200 fax 570-970-2205

Student ID: _____(Keystone will assign)

Student Last Name: _____

Student First Name: _____

School Name: _____

Pharmacy Name: KEYSTONE PROFESSIONAL will be charging your credit card for all medication charges.

Start Date: _____

End Date: _____

LIST ALL PRESCRIPTION AND NON PRESCRIPTION MEDS TO BE DISPENSED BY SCHOOLMED.

Medication/Vitamins *Include RX and OTC	Strength or Dose ie: mg, ml, mcg	Medication Form tablet, capsule, liquid, chew		Dosing Instructions Time of day per dose	Daily or As Needed
1.					
2.					
3.					
4.					
5.					
6.					
7.					

This list MUST match the prescriptions sent to Keystone l. Prescriptions will be dispensed EXACTLY as written by the prescriber. Carefully review all written prescriptions to ensure they are IDENTICAL to your list above. If not, contact physician for new RX prior to sending to Keystone Professional Pharmacy.

Medication is dispensed as GENERIC unless the PRESCRIPTION clearly instructs "BRAND NAME NECESSARY". You may incur a higher co pay from your insurance carrier for the a brand name drug.

*** Over the Counter Meds ***
You do not need a prescription for Over the Counter medicine. the pharmacy will dispense your exact written request.

Medication prescribed to be taken DAILY will be administered in the MORNING unless written above and on the RX.

AS NEEDED medication will be refilled ONLY when requested by the school nurse.

I acknowledge that I am responsible for the cost of any medication not covered by my insurance company, for any medication the pharmacy cannot get reimbursed for, as well as any co-payments, deductibles, and charges for over the counter medicine which I authorize to be charged directly to my credit card by the : Keystone Pharmacy.
If I am submitting insurance information, I agree to authorize the Keystone Pharmacy to contact my insurance company for insurance verification, billing and collections for my student's medications. Our licensed pharmacies are HIPAA compliant and all personal information received will be solely maintained for the purpose of filling prescriptions and processing insurance claims. I understand and agree that I may receive emails from Keystone Pharmacy containing medication information regarding my student.

Signature Of Guarantor_____

Print Name_____ Date_____