**Please complete student information**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ what happens:\_\_\_\_\_\_\_\_\_\_\_\_\_

Any existing medical conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(examples: asthma, high blood pressure, diabetes, hypothyroidism)

**-------------REQUEST TO TRANSFER A PRESCRIPTION------------**

\*Name of Pharmacy Rx is currently at:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Pharmacy Phone #: \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

\*Where is pharmacy located: (city)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (state)\_\_\_\_\_\_\_\_\_\_(zip)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Name of medication to transfer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Rx number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Date needed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OR** Hold until needed \_\_\_\_\_\_

Do you have insurance that covers prescriptions? \_\_YES \_\_NO

If YES, do you have your insurance card with you? \_\_YES \_\_NO

**INSURANCE INFORMATION:**

***Please note: We are NOT contracted with Humana or AHCCCS***

Please bring in a copy of your insurance card when dropping off this form
Thank - you