

Student Name:

Prescription Transfer-In Form

To the student: Please call the pharmacy to verify that we stock your medication. Once you have confirmed that it is available, please complete the following form to the best of your ability. You may then either fax the form in or bring the form to the pharmacy located on the first floor of the Student Health Center. Please allow 48 hours for the processing of transfers.

Date of Birth:

UIN:		Ma	ale [Female
Local Address:		,		
Telephone Number(s):				
Transfer From:				
Pharmacy Name:		Telephone:		
Pharmacy Address (if known):		<u> </u>		
Prescription (RX #)	Medication Name:			
Required Information (please circle):				
Drug Allergies	Health Conditions		Current Medications	
Cephalosporins Codeine	Ulcers Gla	ucoma Cancer		Please List:
Erythromycin Penicillin	Seizures Hep	patitis Thyroid		
Tetracycline Aspirin	Diabetes Astl	nma Pregnand	.y	NONE
Hydrocodone Sulfur Drugs	Migraine Heada	aches High Blood Pr	essure	Birth Control (if
Other: NONE				applicable, circle)
None				PILL DEPO Otho Evra
Student Signature:Date:				