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.

Student Name:	Date of Birth:
UIN:	☐ Male ☐ Female
Local Address:	
Telephone Number(s):	

Transfer From:

Pharmacy Name:	Telephone:
Pharmacy Address (if known):	
Prescription (RX #)	Medication Name:

Required Information (please circle):

Drug Allergies	**Health Conditions**	**Current Medications**
Cephalosporins Codeine Erythromycin Penicillin Tetracycline Aspirin Hydrocodone Sulfur Drugs Other: NONE	Ulcers Glaucoma Cancer Seizures Hepatitis Thyroid Diabetes Asthma Pregnancy Migraine Headaches High Blood Pressure	Please List: NONE Birth Control (if applicable, circle) PILL DEPO Otho Evra

Student Signature:_____ Date:_____