



**Camp Name :**

**Campers Pharmacy/Valley Pharmacy  
CAMP MEDICATION THERAPY MANAGEMENT**



**Parent Registration Form**

Please complete and fax this form 973-584-7266 or scan and email to [info@camperspharmacy.com](mailto:info@camperspharmacy.com)

Please mail the prescriptions and/or manual form to the following address:

**Valley Pharmacy, 107 Route 10 East, Succasunna, NJ 07876, PH: (973) 584-5555 Fax: (973) 584-7266**

Registration Number : (For office Use only)

Camper First Name		Camper Last Name	
Date of Birth		Session Start Date	
Gender		Session End Date	
Registration Deadline			

If more than one child is attending camp, please complete a separate form for each camper.

**Parent/Guardian Information**

Parent / Guardian Name Street Address City	
State / Zip Code	
Email	
Primary Phone Number	
Secondary Phone Number	
Cell Phone Number	
Please list any allergies or other information we should know regarding this camper.	
Drug Allergies	
Other Allergies	
Special Instructions	

**Medication Listing**

Please list all medications (prescription or OTC) that the camper is currently prescribed. We understand that this list might change as we approach camp season.

Medication Name	Dosage	Medication Form	Medication Type( Brand / Generic )	Times of Administration	Directions
Ex: Ibuprofen	200mg	Tablet	Generic	Breakfast	1 Tablet daily

**Note: Please indicate time of administration for each medicine.**

**Parent/Guardian Payment Authorization Form**

<b>Name on Credit Card</b>	
<b>Billing Address</b>	
<b>Billing City/State/Zip</b>	
<b>Type of Card</b>	
<b>Card Number</b>	
<b>Expiration Date</b>	
<b>Security Code</b>	

I acknowledge and assume responsibility and grant authorization for Valley Pharmacy and/or its parent company or affiliates to charge the above credit card for registration and sign-up fees where applicable. I also acknowledge responsibility for the cost of any medication not covered by my insurance company, for any medication that Valley Pharmacy cannot get reimbursement for, as well as any co-insurance and deductibles and charges for OTC/Sundries, which I agree, will be billed to my credit card by Valley Pharmacy.

<b>INSURED NAME:</b>
<b>INSURANCE COMPANY</b>
<b>INSURANCE COMPANY ADDRESS/ CITY/STATE/ZIP</b>
<b>INSURANCE COMPANY PHONE NUMBER</b>
<b>PLAN NAME</b>
<b>TYPE OF INSURANCE (PRIMARY/SECONDARY)</b>

**MEMBER ID**

**GROUP NUMBER**

**BIN NUMBER**

**PCN NUMBER**

I authorize Valley Pharmacy to contact my insurance company for verification of coverage, billing, and collections for my medications. As per our HIPAA agreement, all personal information received will be solely maintained for the purposes of dispensing prescriptions and insurance collection.

---

Parent/Guardian Signature

## Parent/Guardian Insurance Details

Parent/Guardian Insurance Information

Send a copy of both sides of the Parent/Guardian and Camper PRESCRIPTION Insurance card at the same time.



## IMPORTANT

Schedule II controlled substances **MUST** be e-prescribed or written on an original prescription blank and mailed to our pharmacy (e.g. Addreall, Concerta, Ritalin, Vyvanse). They may **NOT** be faxed.

Thank you for your help in making this a smooth and fun camp season for your patient! Please call us with any questions at (973) 512-2949 or email us at [info@camperspharmacy.com](mailto:info@camperspharmacy.com)

Sincerely,

Valley Pharmacy

VALLEY PHARMACY  
107 Route 10 East  
Succasunna, NJ 07876  
Email : [info@camperspharmacy.com](mailto:info@camperspharmacy.com)  
Tel :973-584-5555  
Fax : 973-584-7266

### Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY.

### LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

### USE AND DISCLOSURES OF HEALTH INFORMATION

We are permitted, by law, to use and disclose health information about you for reasons concerning treatment, payment and healthcare operations.

Examples: Treatment: We may disclose your health information to obtain payment for services that we provide you.

Payment: We may use and disclose your health information to obtain payment for service that we provide you.

Operations: We may use and disclose your health information in connection with our healthcare operations, which include administration and planning and other tasks that help us improve that quality.

Family and Friends: We may disclose your health information to a family member, relative or a friend that has been identified by you while you are present. If you are not present, professional judgment will be utilized to determine whether a disclosure is required or in your best interest. We will only disclose information that is believed to be relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your health information in order to notify such persons of your location, general condition or death.

Requirements of the Law: We may use or disclose your health information when we are required to do so by Law.

Victim of Abuse or Neglect: We may disclose your health information to authorities if reasonable belief is that you are a possible victim of abuse, neglect or domestic violence. We may disclose information to the extent necessary to avert additional serious threat to your health or safety or the health or safety of others.

Public Health Activities: We may disclose your health information to public health authorities for the purpose of preventing or controlling disease or preventing injury; to alert a person who may have been exposed to a communicable disease; to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; to report information to a health oversight agency that is responsible for ensuring compliance with governmental rules and regulation, such as Medicare and Medicaid.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence and other national security activities.

Appointment Reminders: We may contact you to provide you with appointment reminders, such as voice messages; including essential information such as time, location and the name of the company/provider.

Worker's Compensation: We may use or disclose your health information to the extent necessary to comply with state laws relating to workers' compensation.

**Disclosures Requiring your Authorization:** For any reasons other than those listed in this notice, we may only use or disclose your health information with your written authorization. Your authorization must also be obtained prior to using your health information for any marketing activity.

#### **YOUR RIGHTS TO YOUR PERSONAL HEALTH INFORMATION**

**Access to Record:** You may have access to your health information, with limited exceptions. Request must be made in writing, utilizing our Record Access Request Form. We may charge a reasonable fee to compensate for time and materials.

**Revocation of your Authorization:** you may revoke your authorization to disclose your health information at any time. Request must be made in writing, using our Authorization Revocation form.

**Restriction of Information:** You may request that we place restrictions on our use or disclosure of your health information. You must make your request in writing by sending a letter that specifies the type of information to be restricted and to whom the information is to be restricted from. Request should be sent directly to the address listed in the heading of this Notice. We will consider all requests; however are not required to agree to the request. We will respond to all such requests in writing.

**Disclosure Accounting:** You may request a list of instances in which we (or our business associates) disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6years, but not before April 14, 2003. You must make your request in writing by sending us a letter that specifies the type of information and the time period involved. Requests should be sent directly to the address listed in the heading of this Notice. if you request this information more than once in a 12-month period, we may charge you a reasonable fee to compensate for our time and materials.

**Alternative Communication:** You may request that we communicate with you about your health information by alternative means or to an alternative location. You must make your request in writing by sending a letter that specifies the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you have requested. Requests should be sent directly to the address listed in the header of this Notice.

**Amendment:** You have the right to request that we amend your health information. You must make your request in writing by sending us a letter that explains why the information should be amended. Requests should be sent directly to the address listed in the header of this Notice. We will comply with your request unless we believe that the information to be amended is accurate and complete.

**Right to Receive Paper Copy of this Notice:** Upon request, you may obtain a paper copy of this notice.

#### **QUESTIONS OR COMPLAINTS**

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we have made about a request for access to your health information, a request you have made to amend or restrict the use or disclosure of your health information or a request you have made for us to communicate with you by alternative means or locations, you may complain to us using the contact information listed in the header of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to the U.S. Department of Health and Human Services upon request.

If you have any questions, concerns or complaints about this Notice, please contact us.

I acknowledge that I have read and understand the following.

1. The registration fee is non-refundable.
2. A late fee of \$30.00 will be charged if registered after the registration deadline.
3. All Controlled Drug Prescriptions should be written out for up to 30 days supply ONLY. If your child is attending camp for more than 30 days, a separate prescription is required for each 30 day period.
4. DO NOT FILL BEFORE date on controlled drug prescriptions should be 2 weeks prior to start of session.
5. All OTC'S require a prescription written by the physician.
6. All prescriptions should be written for the time of day the medicine is to be administered to the camper ( i.e. breakfast, lunch, dinner, bedtime). If the medicine is taken as needed please make sure it is specified on the prescription.
7. All prescriptions will be filled generically (if available) unless otherwise specified by your physician as Do Not Substitute.
8. All prescriptions should be received by the pharmacy 3 weeks prior to start of session or late fee of \$30.00 will be charged.
9. Please make sure that you send a copy of Prescription Insurance Card or the processing of prescriptions will be delayed.
10. I have received a copy of Valley Pharmacy's HIPPA policies.

---

Parent/Guardian Signature