J DRUGS PHARMACY ORDER FORM

1205 AVENUE J BROOKLYN, NY 11230

TEL: 718-258-6686 | FAX: 718-258-1230 | EMAIL: JDRUGSRX@GMAIL.COM

Camper: Last Name **First Name** **Date of Birth** **Gender** **Grade (Fall 2020)**

Address: Street **City** **State** **Zip** **Guardian E-mail Address**

Parent/Guardian Last Name **First Name** **Home Phone** **Cell Phone**

Session I-A/Session I-B/Take 2 | Mini Session 1 | PNW | Session 2/Mini Session 2 | Full Summer/ SIT | Camp Firefly

Dates of Attendance (please circle one)

Allergies

Insurance/Prescription Card

Front of Card

PLEASE CONFIRM THAT ALL DATA IS LEGIBLE
(If you have more than one card please include copies of all cards)

Insurance/Prescription Card

Back of Card

PLEASE CONFIRM THAT ALL DATA IS LEGIBLE
(If you have more than one card please include copies of all cards)

Name of Medication	**Strength**	**Quantity/Time of Day:** (Please circle and fill in)
		breakfast lunch dinner bedtime as-needed other: _____ **# of tabs:_____/_____/_____/_____/_____/_____**
		breakfast lunch dinner bedtime as-needed other: _____ **# of tabs:_____/_____/_____/_____/_____/_____**
		breakfast lunch dinner bedtime as-needed other: _____ **# of tabs:_____/_____/_____/_____/_____/_____**
		breakfast lunch dinner bedtime as-needed other: _____ **# of tabs:_____/_____/_____/_____/_____/_____**
		breakfast lunch dinner bedtime as-needed other: _____ **# of tabs:_____/_____/_____/_____/_____/_____**

(if there are more medication than lines provided please attach a second page)

PAYMENT: VISA AMERICAN EXPRESS OR MASTERCARD:

I hereby authorize J Drugs to charge my credit card all co-payments associated with the medication that I order. I agree to pay for any items that are not covered by my insurance plan.

Card Holder Name Card Number Expiration Date / CVV Code

Card Holder Signature Date

Please Mail, Fax, or Email forms to the address listed above.

Please attach all prescriptions not submitted by your doctor

J drugs is a third-party provider and is not associated with the camp