



2009-2010 Prescription Medication Payment Arrangements

This form is a vitally important part of your daughter's health record.
We cannot have prescriptions filled for your daughter without this information.

Student Name: _____ Date: _____

1. _____ A copy of my insurance/drug card is attached. I wish for this card to be used for all prescriptions for my daughter.

Card Holder's Birthdate: _____
Month Day Year

2. _____ I have an account with Hawthorne Pharmacy that I intend to continue to use.

3. _____ I plan to set-up and account with Hawthorne Pharmacy

Hawthorne Pharmacy
1622 South Hawthorne Road
Winston-Salem, NC 27103
Phone: 336-768-1815

4. _____ My daughter will pay for her own medicines.

5. _____ Additional funds will be placed in my daughter's account for prescriptions

6. _____ Other: _____



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