Prescription Delivery Request & Consent

Indiana University Health Center Pharmacy

Student Name: _____

University ID Number: _____

Campus Residence Hall & Room Number: _____

Cell Phone Number: ( ) _____

Prescription(s) to be delivered: _____

_____

By signing below, I am providing my consent to have the above prescriptions delivered to the location provided by me. Further, I understand the following:

- *I agree to allow the Indiana University Health Center to transfer all balances due relating to these prescriptions to my Bursar's account at Indiana University.*
- *I agree to allow these prescriptions to be delivered to, received, processed and held by the central office mailroom of the Indiana University dormitory in which I reside.*
- *I agree that should I fail to pick up my prescriptions those prescriptions will be returned to the Indiana University Health Center.*
- *I agree that I will still be responsible for the cost of these prescriptions even if those prescriptions are not picked up by me.*
- *That it is my responsibility to inform the Indiana University Health Center Pharmacy if and when I should need to change or cancel the delivery of my prescriptions*
- *I agree to allow the Indiana University Health Center to send me SMS/text messages via my personal cell phone for notifications relating to my prescription delivery.*

I have read and understand the above risks and requirements and do hereby grant my consent for the Indiana University Health Center to deliver my prescriptions to the address provided above.

_____ _____

Student Signature Date

Please feel free to either hand deliver this form to our Pharmacy,
fax it to 812-856-7777, or email a scanned copy to
myhealth@indiana.edu