

WELCOME TO THE SHAC!!

Questions??? Call 505-277-6306

ITEMS NEEDED TO TRANSFER A PRESCRIPTION OR IF YOU ARE NEW TO US.

NAME: _____ **Preferred name:(** _____ **)**

DOB: _____

STUDENT ID #: _____

CELL PHONE # _____

ADDRESS (HERE OR HOME) _____

CITY, STATE & ZIP: _____

DRUG ALLERGIES:

HEALTH CONDITIONS:

IF TRANSFERRING: NAME OF PHARMACY YOUR ORDER IS AT AND THEIR PHONE NUMBER

PRESCRIPTION INSURANCE (MAY BE DIFFERENT THAN MEDICAL)

RX BIN: _____

RX PCN: _____

ID: _____

RX GROUP: _____

PERSON CODE:



**STUDENT HEALTH
& COUNSELING**

THANK YOU 😊