PHARMASAVE®

LONG SAULT PHARMACY

PATIENT CHECK-IN

First Name:		Last Name	
DOB (Day/Month/Year):			
Address:			
Primary HCP:			
Email Address:			
Cell:			
Assigned Sex at birth:	Male or Female		

Acknowledgment of Medical Directive:

I understand that I will fill out this questionnaire as completely and accurately as possible as it is used to make travel health recommendations for my particular trip.

I understand and consent that this medical information may be shared with the Riverside Travel Clinic and Dr. Peter Teitelbaum for the sole purpose of providing travel health medical services for your trip.

I understand and consent that vaccines may be prescribed and administered by a registered pharmacist Bryan Haley (license # 605668) under a medical directive provided by Dr. Peter Teitelbaum of the Riverside Travel Clinic and a copy of the medical directive can be provided to you upon request.

I understand that health card information provided may be used to access online medication records.

I understand that I have a choice where medications and vaccines prescribed through this service, may be sent to a pharmacy of my choosing.

Date:		Patient Signature:	