ROCKHILL PHARMACY
LONG TERM CARE SERVICES

Request for Pass Medications

Patient _____ Date_____

Facility _____ Ordered by_____

Date Leaving ____/_____/_____ Time ___:___

Date Returning ____/_____/_____ Time ___:___

Prescriptions for home use are required to be packaged in safety vials ("Child-Proof Caps") unless otherwise specified non-safety vials by patient. Signing below will allow the pharmacy to package in either container.

I DO NOT want Rockhill Pharmacy to package my meds in "Child-Proof" safety vials. I understand the facility or the pharmacy will not be responsible for any medication errors, loss, or improper administration while the medications are in my possession.

_____ Date____/____/_____
Signature of person receiving medication

_____ Date____/____/_____
Signature of person releasing medications

4235 Locust Street ▪ P. O. Box 5930 ▪ Kansas City, MO 64171 ▪ Telephone (816) 799-0123 Fax (816) 931-0282