MEMORIAL HOSPITAL
Since 1962
Chester, Illinois

Memorial Community Pharmacy
1900 State Street Rm. 100
Chester, IL 62233 618-826-6134

Prescription Delivery Kiosk Service
Patient Acknowledgement, Agreement, and Consent Form

I, the undersigned, hereby agree to receive drugs and/or devices prescribed to me through Memorial Community Pharmacy Prescription Delivery Kiosk Service (PDKS).

Furthermore, I affirm that:

1. I have been informed that I have the right to consultation for my medications dispensed through the PDKS on the following instances:
    1. (i). Upon request; or
    2. (ii). Whenever the pharmacist deems it warranted in the exercise of his or her professional judgment;
    3. (iii). Whenever the prescription drug has not previously been dispensed to a patient; or
    4. (iv). Whenever a prescription drug not previously dispensed to a patient in the same dosage form, strength or with the same written directions, is dispensed by the pharmacy.
    5. (v). Consultation will be with a Memorial Pharmacist during business hours and with a contracted service after hours.
2. I have been instructed on the proper use of the PDKS; and when to expect my prescriptions if NOT available in the PDKS, or when the PDKS is disabled or malfunctions.
3. My use of the PDKS does not interfere with the delivery of drugs and/or devices prescribed to me.
4. I am aware that I may revoke this authorization from the Pharmacy any time, and upon written notice to the Pharmacy.

Attestation

I have read and understand the entirety of this document, and I voluntarily give my consent to Memorial Community Pharmacy to enroll myself in the Prescription Kiosk Delivery program.

_____ _____

Patient (Parent/Guardian) Name and Signature Date

I give_____ permission to pick up my prescriptions and receive my notifications.