PHARMACY INFORMATION

Patient Name: _____ Date of Birth: _____

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

Pharmacy Telephone Number: _____

SPECIFIC INFORMATION TO YOUR CHILD

Please circle

Your child's race: Asian, Black, Chinese, Filipino, Hispanic, Japanese, Native American, Native Hawaiian, White, Undetermined, Patient refusal

Your choice of language: Chinese, English, French, Italian, Spanish, Vietnamese, Patient refusal

Your child's ethnicity: Caucasian, Hispanic, Not Hispanic, Patient refusal

Thank you for taking the time to complete this information.