

**PARENT/GUARDIAN FORM 13**

\_\_\_\_\_  
Cadet Name Last, First, MI

SUBJECT: Pharmacy Authorization **“THIS INFORMATION IS CONFIDENTIAL”**

1. The Academy’s pharmacy requires that each Cadet’s parent/guardian provide a valid Visa or MasterCard so that their child’s prescriptions may be charged to this card. The pharmacy will not bill parents or guardians directly. They will accept third-party prescription cards if they have a contract with the company, or they will fill out any forms for reimbursement that you send them.

2. I/we the undersigned, are providing Massanutten Military Academy with the following credit card information and authorize the Academy’s representative to use this information for the sole purpose of charging my/our child’s prescriptions.

Cadet’s full name \_\_\_\_\_ Birth Date \_\_\_\_\_

Indicate the Cadet’s Drug Allergies by circling:

Penicillin	Erythromycin	Codeine	Sulfa Drugs
Keflex, Ceclor	Tetracycline	Aspirin	None
Other: _____			

Cadet’s Chronic Conditions or Disease: \_\_\_\_\_  
\_\_\_\_\_

Over-the-Counter Medicines used regularly: \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,

Name and address of parent/legal guardian: \_\_\_\_\_  
\_\_\_\_\_

Parent/guardian phone numbers: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
(C) \_\_\_\_\_

Home phone number of guardian: \_\_\_\_\_

Visa or MasterCard number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(If you do not have either of these cards, a \$150 deposit is required for needed medical supplies)

Please ensure that the Academy has a clear copy of both sides of your prescription cards.

\_\_\_\_\_  
Parent(s) Signature Date

\_\_\_\_\_  
Credit card holder’s signature if different from Parent Date

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