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Patient: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

**Text message reminders**

Please check one of the following boxes:

- Yes, I want to sign up for text message reminders
- No, I do not want to sign up for text message reminders

If you selected **YES** please provide the number you would prefer to receive text messages on:

\_\_\_\_\_

**E-prescribing system**

Please provide your preferred pharmacy below:

**Local pharmacy:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Mail order pharmacy (if applicable):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**\*\*This information is used for our records only and WILL NOT be distributed\*\***