REQUEST AND CONSENT FOR ACCEPTANCE AND STORAGE OF MEDICATIONS

WWU Student Health Center (SHC) can assist you in receiving and storing medications that need to be shipped directly to a health care facility. If you have a medication that needs to be shipped directly to a health care facility, and you wish to have the medication shipped to the SHC, fill out the attached form and send it to us via MyWesternHealth.wwu.edu or FAX 360-650-3883. Only medications that are approved will be stored at the SHC.

Medications will be received and stored at the SHC. It is a secure facility, accessible only by university personnel. Medications that require refrigeration are stored in a refrigerator with a temperature monitoring system and alarm. **Please note that the SHC cannot be responsible for shipping issues, breakage or loss of medication(s).**

Note the shipping address and hours of operation below. **It is your responsibility to arrange for shipment of your medication to the WWU Student Health Center.** Shipments are only received and medications only retrievable during the SHC hours of operation.

Shipping Address:
WWU Student Health Center
2001 Bill McDonald Parkway STE202
Bellingham, WA 98225

- Hours of Operation for WWU Student Health Center:

Fall, Winter & Spring Quarters:	8:30 am - 4:00 pm, Mon, Tues, Wed and Fri 9:30 am – 4:00 pm on Thursday Closed Saturday & Sunday
Summer:	8:30 am – 12pm & 1pm – 4:00 pm Mon-Fri Closed Saturday & Sunday
Closed Holidays and during campus closures	

In order to have your medication administered at the Student Health Center, you must first make an appointment with a Student Health Center provider. Call 360-650-3400, option 1 to request an appointment.

You must have an appointment each time you need your medication administered.

When you no longer wish to have medication shipped to the Student Health Center, you must contact the supplier of the medication to change the shipping address. Contact the Student Health Center directly at 350-650-3400 to indicate that you will no longer be storing medication at the SHC, and to arrange for return of any unused medication supply.

REQUEST TO WWU STUDENT HEALTH CENTER TO RECEIVE AND STORE MEDICATION

Patient Name	W#	Date of Birth	Date
_____	_____	_____	_____

Patient's Phone Number: _____

Name of Medication, Dose, Directions: _____

Date next dose of medication is due _____

Prescribing Physician: _____ Physician's Phone Number _____

Physician Address: _____

Supplier of Medication (pharmacy): _____ Supplier's Phone Number _____

Consent for Acceptance and Storage of a Medication Prescribed by an Outside Health Services Provider

1. I, _____ (patient name), being 18 years of age or more, hereby consent and authorize Western Washington University Student Health Center (WWU SHC) staff to accept receipt of and store the medication listed above.

   _____ (medication name).

2. I understand that the WWU Student Health Center does not supply my medication and is not responsible for maintaining supply of my medication. I am responsible for all communications with the supplier of my medication, and I am responsible for ensuring that there is adequate supply of my medication available for administration.
3. I understand that I am responsible for arranging shipment of my medication to the WWU SHC.
4. I understand that shipments can only be received and are only retrievable during the Student Health Center hours of operation.
5. I do not hold the WWU SHC responsible for any administration, storage or refrigeration problems.
6. I understand it is my responsibility to change the shipping address with the supplier of my medication for shipment of my medication and supplies during the holiday periods and breaks if I need to continue the medication elsewhere during that time.
7. If I stop treatment and do not arrange for shipment of my medication and supplies to another medical facility, WWU Student Health Center staff will discard my medication at the expiration date or at the end of the enrollment session, whichever comes first.
8. I understand that I must make an appointment with a provider at SHC to arrange for administration of my medication if needed, and I must make an appointment with a nurse each time I need administration of the medication.
9. I have read and fully understand this consent form.

Patient's printed name	W# number	Phone number
_____	_____	_____

Patient's signature	Date signed
_____	_____