REQUEST FOR NON-CHILD PROOF CAPS ON MEDICATION FILLS AT KIMBROUGH AMBULATORY CARE CENTER

1. Please fill the following medications with non-child proof caps:

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

   f. _____

   g. _____

   h. _____

   i. _____

   j. _____

   k. _____

   l. _____

   m. _____

   n. _____

   o. _____

2. I am aware that bottles that have this type of cap are easy to open and should be kept away from children and pets to avoid possible injury.

3. I also understand that I will be required to fill out this form every time I present to the pharmacy at Kimbrough Ambulatory Care Center to have medications filled and desire non-child proof caps.

Printed name of requester	Signature	Date

MEDDAC (Ft Meade) Form 750
1 Oct 02