



Mobile Free Pharmacy Homebound

- YOU MAY SELECT A TOTAL OF 4 ITEMS
- NO MORE THAN 2 ITEMS PER CATEGORY (Shaded Areas)

Cough, Cold, & Flu	Allergy	Laxative/ Hemorrhoids	Pain Relief	Digestive Aids	Vitamins	Skin Treatment
Cough Syrup	Nasal Spray	Stool Softeners	Ibuprofen (Advil)	Heartburn Relief	Calcium	Anti-fungal
Daytime Cold	Allergy Relief	Enemas	Aspirin 81 mg	Fiber	Vitamin C	Anti-Itch
Nighttime Cold	Benadryl	Hemorrhoid Cream	Aspirin 300 mg	Anti-Diarrheal	Fish Oil	
		Laxatives	Pain Relief	Gas Relief	Multivitamins	
		Please write in three (3) additional items that may not be listed (that you may need): We will provide these items if we have them available.				

I promise that this medicine will be used for myself and not returned to a store, sold for profit, or given away.
 (Yo prometo que esta medicina va a ser usada por mí y no devuelta a una tienda, vendida para lucro, o regalada).

Signature: _____ Date: _____



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Your Name (Nombre): _____

Street Address (Direccion): _____ Apt/Unit: _____ City (Ciudad): _____

Zip Code (Codigo Postal): _____ Email (Correo Electronico): _____ Phone (Telefono): _____

Gender (Sexo): FEMALE (Mujer) MALE (Hombre) Age (Edad): _____

Ethnicity (Etnia): Caucasian/White African American/Black American Indian/Alaska Native Asian Latino/Hispanic
Bi-Racial/Multi-Racial Native Hawaiian/Pacific Islander Other: _____

**How did you hear about this event?
(Como escucho de este evento?)**

___ I am a MedAssist Client

___ DSS

___ Flyer

___ Friend/Family

___ Clinic/Dr. Office/Hospital

___ Shelter

___ Radio

___ Newspaper

___ Television

Please complete the following Survey Questions (Por favor complete last siguientes preguntas):

⇒ Do you currently have insurance? (Usted tiene seguro medico?):

___ Medicaid ___ Medicare ___ Private Insurance (Seguro Privado) ___ No Insurance (No Seguro)

⇒ If you selected **No Insurance**, do you need help paying for your prescription medications?

(Si usted seleccionó **No Seguro**, necesita ayuda para pagar por sus prescripciones?)

___ **Yes (Si)**, please contact me by: (Por Favor contacteme por):

___ Address (My dirección) ___ Email (Correo electrónico) ___ Phone (Telefono)

___ **No**, I am not interested at this time (No estoy interesado)

Notice: Under North Carolina law, a volunteer medical or health care provider shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the medical or health care provider's voluntary provision of health care services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer or health care provider.

Aviso: Bajo la ley de Carolina del Norte, un médico voluntario o proveedor de atención médica no será responsable de los daños por lesiones o muerte alegada por haber ocurrido un acto u omisión en la provisión voluntaria de servicios médicos por parte del médico o proveedor de atención médica, se establece que las lesiones o la muerte fueron causadas por una negligencia grave, una conducta desenfrenada o una mala conducta intencional por parte del voluntario o proveedor de atención médica.

Signature: _____ **Date:** _____