



Medication Delivery and Storage Release Form

Student/Learner Information

- **Name:** _____
- **Student ID #:** _____
- **Date of Birth:** _____
- **Phone/Email:** _____

1. Purpose

This form authorizes Johns Hopkins University Student Health & Well-Being Primary Care (SHWB PC) to **receive, store, and/or dispense medications** delivered on behalf of the student named above.

2. Medication Information

(Complete one form per medication if needed)

- **Medication Name:** _____
- **Dosage/Strength:** _____
- **Prescribing Provider:** _____
- **Pharmacy Name:** _____
- **Expected Delivery Method:** FedEx UPS Pick-up by student Other:

- **Expected Delivery Schedule:** _____

3. Delivery Authorization

I authorize SHWB PC to **accept delivery** of the above medication on my behalf. I understand that:

- SHWB PC will sign for the package and log its receipt.
- Deliveries are only accepted during hours of operation.



- SHWB PC is **not responsible for delays, shipment errors, or damage** incurred during transit.
- SHWB PC does not accept delivery of any controlled substances or stimulants.
- For all cases wherein SHWB PC will receive delivery of medications **ONLY**, medications not collected within **7 days** may be returned or disposed of according to clinic policy.
- SHWB PC staff will notify me when the medication arrives.

4. Storage and Handling

I authorize SHWB PC to **store my medication** under proper conditions (e.g., refrigeration if required). I understand that:

- SHWB PC will maintain temperature-appropriate storage in a refrigerator with temperature monitoring system and alarm but cannot guarantee control over factors beyond its facility's standards.
- Staff will notify me by secure message when the medication arrives.
- I am responsible for timely pick-up (within 7 days) and for verifying medication package integrity upon receipt.
- I am responsible for making an appointment if the medication is to be administered by a clinical staff member.
- I am responsible for changing shipping address for holiday periods/breaks/clinic closures or when stopping delivery all together.
- If I do not make an appointment to have the medication administered or do not change the shipping address for holidays/breaks, the clinic will attempt to contact me by phone and secure message (at least three attempts total). If no response is received, medication will be disposed of per clinic protocol.

5. Outside Provider Medication Administration Instructions

If you need a SHWB PC staff member to administer the medication, please provide us with a signed copy of your prescription, dosage, and instructions for administration from the ordering provider.

6. Liability Release

By signing below, I voluntarily release and hold harmless Johns Hopkins University, including Student Health & Well-Being Primary Care, its trustees, officers, employees and agents from any and all liabilities, losses, thefts, delays or damages to medications delivered or stored at the facility, except as required by law in cases of negligence or willful misconduct.



I represent and certify that I am over 18 years of age, or if I am under the age of 18 years, I represent and certify that I have the permission of my parent or legal guardian to authorize SHWB PC to receive, store and/or dispense medications delivered on my behalf, and that he or she has full knowledge thereof and has indicated his or her agreement by signing below.

To be completed if student is under 18 years of age:

Parent/Legal Guardian's Full Name

Signature

Date

7. Acknowledgment

I have read and understood this agreement. I accept responsibility for my medication delivery, storage, and timely retrieval.

Student Signature: _____ **Date:** _____

SHWB PC Staff Witness: _____ **Date:** _____