

SICK(Self Initiated Care Kit) Program

Dyess AFB, TX
(325) 696-5323



Instructions: Fill out a separate form for each patient. Provide the **PATIENT'S** information where asked. Complete this form, then pull a ticket to drop off a new prescription and turn in this completed form when your number is called.

Patient

Name: _____
 DOB: _____ Sponsor Last 4 SSN: _____
 Allergies: _____

Answer ALL of the following questions for the PATIENT:

Yes or No	Less than 12 years old?	Yes or No	On PRP or Flying status?
Yes or No	Less than 6 years old?	Yes or No	Pregnant or breastfeeding?
Yes or No	Less than 2 years old?	Yes or No	Symptoms lasting 7 or more days? (except allergies)
		Yes or No	Fever at or above 101.1°F for 3 or more days?

Place an X next to the medications you would like (MAX OF 3):

X	Medication	Use	Age for use
	Adult Tylenol 325mg tabs	Fever/Aches/Pains	Ages 12 and up
	Adult Ibuprofen 400mg tabs	Fever/Aches/Pains	Ages 12 and up
	Robitussin DM	Cough Suppressant	Ages 12 and up
	Afrin Nasal Spray	Nasal Congestion	Ages 6 and up
	Zyrtec	Seasonal Allergies	Ages 6 and up
	Claritin	Seasonal Allergies	Ages 6 and up
	Children's Zyrtec	Seasonal Allergies	Ages 2 and up
	Children's Tylenol	Fever/Aches/Pains	Ages 2 and up
	Children's Ibuprofen	Fever/Aches/Pains	Ages 2 and up

Did you reference the familydoctor.org website (either through tricareonline.com or directly?)

YES NO

Did you use the Nurse Advice Line to help you determine the severity of your symptoms and best treatment options?

YES NO

Did you avoid making an appointment with your PCM, or using MiCare to message your PCM team because this service was available?

YES NO

Are there any other over-the-counter medications you would like available? _____

By signing below, I certify the following:

- I understand this medication is for minor illnesses or conditions only
- If symptoms worsen or do not improve, the patient should be seen by a medical provider
- I do not require any additional education or counseling for any medications in the SICK program
- This medication will be used by the eligible TRICARE beneficiary listed above
- There is a limit of 3 medications per beneficiary per month
- All of the information provided above is true and accurate to the best of my knowledge

Patient/Guardian Signature: _____ Date: _____

Pharmacist Signature: _____ Date: _____