

Prescript Aid *** CUSTOMER PROFILE ***** (Pres22sw)**

First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ Country: _____ Zip Code: _____

Phone Number () _____ - _____ Alt Phone Number () _____ - _____

Birth Date: MM / DD / YYYY Weight: _____ lbs. Gender: _____ male _____ female

Smoker? _____ yes _____ no Pregnant? _____ yes _____ no Nursing? _____ yes _____ no

List Allergies: _____

List Current Medications: _____

YOUR MEDICAL HISTORY

Please check ? all applicable fields

- | | |
|--|--|
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid arthritis, lupus, or connective tissue disease |
| <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome |
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Renal or Kidney disease |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Drug allergies |
| <input type="checkbox"/> Emotional disorders | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Hyperlipidemia (high cholesterol) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> Heart Disease including atherosclerosis, angina, heart failure or history of heart attack | <input type="checkbox"/> Other illness not yet noted |
| <input type="checkbox"/> Lung disorder (i.e., asthma, emphysema) | |

If you checked off any of the above medical conditions please provide details in the space below.

CREDIT CARD INFORMATION *** Please do not send checks ***

Please charge to the following credit card: VISA MC AMEX DISCOVER

Name as it appears on Credit Card: _____

Credit Card Number: _____ - _____ - _____ - _____

Expiry Month: _____ Expiry Year: _____

Signature of Cardholder: _____

REALFAST DRUGSTORE.com AGREEMENT AND RELEASE

Please print out and mail.

No prescriptions will be filled without a signed and dated copy of this form
The undersigned, being over the age of 21, hereby:

1. Represents and confirms to RealFast Drugstore.com that the pharmaceutical(s) to be delivered to the undersigned were prescribed by a doctor licensed to practice medicine in the country, state or other applicable jurisdiction in which the undersigned resides, that the prescription(s) for the pharmaceuticals were lawfully obtained from that physician and that the pharmaceutical(s) will be used only as directed and only by the person for whom the pharmaceutical was prescribed;
2. Releases and discharges RealFast Drugstore.com and all of their agents, affiliates and employees, from any and all liability, claims or causes of action with respect of the appropriateness, suitability, strength or dosages of the pharmaceutical(s) prescribed for the undersigned, including, without limiting the generality of the foregoing, any side or ill effects whatsoever of any kind or nature, and confirms that the undersigned did not rely on Real Fast Drugstore with respect to the nature of the pharmaceuticals prescribed, other than to fill the prescription in accordance with its plain terms. The undersigned understands and acknowledges that the pharmaceutical(s) will not be packaged in child protective packaging and the undersigned releases and discharges RealFast Drugstore.com all of their agents, affiliates and employees from any and all causes of action with respect to the non-delivery or misdelivery of the pharmaceutical(s) sent to the undersigned.
3. Authorizes and appoints RealFast Drugstore.com as his or her agent and as his or her attorney for the limited purpose of taking all steps and to sign all documents on behalf of the undersigned necessary to deliver the prescription documents from RealFast Drugstore.com in the form required by Province of Manitoba law to RealFast Drugstore.com where it will be filled and returned to RealFast Drugstore.com sent by it to the undersigned as if the undersigned were personally present in Winnipeg, Province of Manitoba, Canada, and taking those steps and signing those documents him or herself.
4. Authorizes and appoints RealFast Drugstore.com as his or her agent and as his or her attorney for the purpose of taking all steps and to sign all documents on behalf of the undersigned necessary for shipping his or her prescribed pharmaceuticals to the undersigned as if the undersigned has shipped the prescribed pharmaceuticals to himself or herself from Manitoba, Canada, to the undersigned's address.
5. Agrees that the courts of Manitoba, Canada, shall hear any dispute that arises between him or her and RealFast Drugstore.com that the courts of Manitoba, Canada shall have the sole and exclusive jurisdiction and that the law of Canada shall apply to any and all disputes that may arise.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THESE TERMS AND AGREES THAT THEY SHALL BE BINDING UPON THE UNDERSIGNED AND HIS OR HER HEIRS, SUCCESSORS AND PERSONAL REPRESENTATIVES.

Signed

Witnessed

Print Name Here

Print Name of witness here

Date

Place of signature and witnessing

AGREEMENT TERMS

*** Please read the following terms carefully prior to registering with RealFast Drugstore.com.

I, _____ (Print Name) am aware and agree to the terms listed below prior to registering with RealFast Drugstore.com.

- I have taken every precaution to access knowledge in pricing/shipping information from RealFast Drugstore.com prior to registration.
- I understand that Prescription drugs I purchase from Canada are approved by Health Canada and carry a Drug Identification Number (DIN), the Canadian version of the US NDC.
- I give RealFast Drugstore.com authorization to bill my Credit Card in terms to agreeing with the prices that have been provided to me.
- I am aware that all prescriptions that I or my doctor are sending to RealFast Drugstore.com contain medications that have been prescribed to me and I am agreeing to have all prescriptions that I have sent filled by your pharmacy.
- I am aware that it is against Canadian Pharmacy law to return/refund medications that have already been sent out to me.

According to the Pharmaceutical Act, if a medication has a Generic version, the Generic version will be dispensed unless the consumer states that only the Name Brand version of the medication is to be dispensed.

- Please send me a generic version of my medication(s) if available
- Please do not send me generics

By signing below, I have read the terms and agreements above and agree to abide by them.

Customer Signature _____ Date _____