

FAMILY PROPHYLAXIS/SCREENING/CONSENT/MEDICATION FORM

Last name: _____ **First name:** _____
Address: _____ **City** _____ **State** _____ **Zip** _____
Home phone: _____ **Cell phone:** _____

Have you or anyone for whom you are picking up the medication been exposed to a suspected biological agent or been in contact with someone who has been infected? Yes No If yes, how _____

Medical History/Treatment Information

	Person #1		Person #2		Person #3		Person #4		Person #5	
First Name										
Last Name										
Birth date & Sex	/ /	<u>M</u> <u>F</u>	/ /	<u>M</u> <u>F</u>	/ /	<u>M</u> <u>F</u>	/ /	<u>M</u> <u>F</u>	/ /	<u>M</u> <u>F</u>
Weight - Children										
Relationship to the individual picking up medication										
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Any symptoms										
Allergic to any medications										
Pregnant										
Breast Feeding										
Organ Transplant										
Hepatitis/Liver disease										
Epilepsy										
Kidney Disease										
Current Medications										
Do Not Write	Below this Box									
Medication & dosage	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____	<u>Ciprofloxacin</u> 500mg BID _____ Other dosage _____ <u>Doxycycline</u> 100mg BID _____ Other dosage _____ <u>Amoxicillin</u> 250mg TID _____ Other dosage _____ <u>Other</u> _____ Dosage _____
Qty Dispensed										
Disease										
Manu/Lot #										

**THIS IS A SAMPLE INTAKE FORM
 THE ACTUAL INTAKE FORM YOU
 WILL USE MAY VARY**

I have read or have had explained to me the information on the fact sheets about the disease and medication. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefit and risks of the prescribed medication. I consent to receive the medication for myself, my children and other persons named/listed on this form. I will share the information with and distribute the medication to those persons listed.

Signature of the person picking up the medication: _____ **Date:** _____
Administered by: _____ **Date:** _____ **Location/Site** _____