|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  **+Name (Person #1):** |       |  |       |  |       | Official Use Only |
| Last Name |  | First Name |  | M.I. | **TIME IN:****TIME OUT:**  |  |
| **Address** |       |  |       |  |       |  |       |
| Street |  | Apt. # |  | City |  | Zip Code | [ ]  Forms Checked |  |
| **Phone** |       |  |       |  |       |  |  |
| Main # |  | Other # |  | County |  |  |
| **PLEASE PRINT** | **Person #1** | **Person #2** | **Person #3** | **Person #4** | **Person #5** |
| **LAST NAME:** | **Name Above****(Person picking up)** |       |       |       |       |
| **FIRST NAME:** |       |       |       |       |
| **BIRTHDATE:** |       |       |       |       |       |
| (MM / DD / YYYY) | (MM / DD / YYYY) | (MM / DD / YYYY) | (MM / DD / YYYY) | (MM / DD / YYYY) |
| **SEX at birth:** | [ ]  Male [ ]  Female | [ ]  Male [ ]  Female | [ ]  Male [ ]  Female | [ ]  Male [ ]  Female | [ ]  Male [ ]  Female |
| **WEIGHT,** only if LESS than 76 pounds**:** | #      pounds | #      pounds | #      pounds | #      pounds | #      pounds |
| **Pregnant/Breastfeeding** | [ ]  Yes [ ]  No/NA | [ ]  Yes [ ]  No/NA | [ ]  Yes [ ]  No/NA | [ ]  Yes [ ]  No/NA | [ ]  Yes [ ]  No/NA |
| **Allergic to Doxycycline?** | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| **Allergic to Ciprofloxacin?** | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| **Allergic to Amoxicillin?** | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No  | [ ]  Yes [ ]  No |
| **C:\Documents and Settings\lynnette\Application Data\Microsoft\Media Catalog\Downloaded Clips\cla4\j0411306.wmfC:\Documents and Settings\lynnette\Application Data\Microsoft\Media Catalog\Downloaded Clips\cla4\j0411306.wmf** I have been afforded medical fact sheets as well as medicine for those listed on this form and I agree to provide both information and medicine, as required. I understand this medicine is to prevent illness, but if illness should occur, it is realized a physician should be seen. I have received and understand my rights under the Health Insurance Portability and Accountability Act (“HIPAA”). |
| **Signature (Person #1):** |  |
|  |  |
| **STOP! Do NOT fill out the information below.** |
|  | **Person #1** | **Person #2** | **Person #3** | **Person #4** | **Person #5** |
| **Dispenser Initials** | Medication |  Doxycycline |  Doxycycline |  Doxycycline |  Doxycycline |  Doxycycline |
|  Cipro |  Cipro |  Cipro |  Cipro |  Cipro |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dosage |  100mg BID |  100mg BID |  100mg BID |  100mg BID |  100mg BID |
|  500mg BID |  500mg BID |  500mg BID |  500mg BID |  500mg BID |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Labeling | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lot#\_\_\_\_\_\_\_\_\_\_\_\_ | Lot#\_\_\_\_\_\_\_\_\_\_\_\_ | Lot#\_\_\_\_\_\_\_\_\_\_\_\_ | Lot#\_\_\_\_\_\_\_\_\_\_\_\_ | Lot#\_\_\_\_\_\_\_\_\_\_\_\_ |
| NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ | NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ | NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ | NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ | NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ |
| **PLEASE PRINT** | **Person #6** | **Person #7** | **Person #8** | **Person #9** | **Person #10** |
| **LAST NAME:** |       |       |       |       |       |
| **FIRST NAME:** |       |       |       |       |       |
| **BIRTHDATE:** |       |       |       |       |       |
| (MM / DD / YYYY) | (MM / DD / YYYY) | (MM / DD / YYYY) | (MM / DD / YYYY) | (MM / DD / YYYY) |
| **SEX:** | [ ]  Male [ ]  Female | [ ]  Male [ ]  Female | [ ]  Male [ ]  Female | [ ]  Male [ ]  Female | [ ]  Male [ ]  Female |
| **WEIGHT,** only if LESS than 76 pounds**:** | #      pounds | #      pounds | #      pounds | #      pounds | #      pounds |
| **Pregnant/Breastfeeding** | [ ]  Yes [ ]  No/NA | [ ]  Yes [ ]  No/NA | [ ]  Yes [ ]  No/NA | [ ]  Yes [ ]  No/NA | [ ]  Yes [ ]  No/NA |
| **Allergic to Doxycycline?** | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| **Allergic to Ciprofloxacin?** | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| **Allergic to Amoxicillin?** | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |

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|  | **Person #6** | **Person #7** | **Person #8** | **Person #9** | **Person #10** |
| **Dispenser Initials** | Medication |  Doxycycline  |  Doxycycline |  Doxycycline |  Doxycycline |  Doxycycline |
|  Cipro |  Cipro |  Cipro |  Cipro |  Cipro |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dosage |  100mg BID |  100mg BID |  100mg BID |  100mg BID |  100mg BID |
|  500mg BID |  500mg BID |  500mg BID |  500mg BID |  500mg BID |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Labeling | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ | Rx#\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lot#\_\_\_\_\_\_\_\_\_\_\_\_ | Lot#\_\_\_\_\_\_\_\_\_\_\_\_ | Lot#\_\_\_\_\_\_\_\_\_\_\_\_ | Lot#\_\_\_\_\_\_\_\_\_\_\_\_ | Lot#\_\_\_\_\_\_\_\_\_\_\_\_ |
| NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ | NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ | NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ | NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ | NDC#\_\_\_\_\_\_\_\_\_\_Expiration \_\_\_\_\_\_\_ |
| **Refer to Primary Care Provider** [ ]  Yes [ ]  No Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Notes (For Official Use Only):  |