|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **+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): | | | | | | |