

+Name (Person #1): _____ Last Name First Name M.I.				Official Use Only TIME IN: TIME OUT: <input type="checkbox"/> Forms Checked	
Address _____ Street Apt. # City Zip Code					
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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
WEIGHT, only if LESS than 76 pounds:	# _____ pounds	# _____ pounds	# _____ pounds	# _____ pounds	# _____ pounds
Pregnant/Breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA
Allergic to Doxycycline?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergic to Ciprofloxacin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergic to Amoxicillin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



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	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____
	Dosage	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____
	Labeling	Rx# _____ Lot# _____ NDC# _____	Rx# _____ Lot# _____ NDC# _____	Rx# _____ Lot# _____ NDC# _____	Rx# _____ Lot# _____ NDC# _____	Rx# _____ Lot# _____ NDC# _____

	Expiration _____	Expiration _____	Expiration _____	Expiration _____	Expiration _____
PLEASE PRINT	Person #6	Person #7	Person #8	Person #9	Person #10
LAST NAME:					
FIRST NAME:					
BIRTHDATE:					
SEX:	(MM / DD / YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female	(MM / DD / YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female	(MM / DD / YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female	(MM / DD / YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female	(MM / DD / YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female
WEIGHT , only if LESS than 76 pounds:	#_____ pounds	#_____ pounds	#_____ pounds	#_____ pounds	#_____ pounds
Pregnant/Breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA
Allergic to Doxycycline?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergic to Ciprofloxacin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergic to Amoxicillin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

STOP! Do NOT fill out the information below.



		Person #6	Person #7	Person #8	Person #9	Person #10
Dispenser Initials	Medication	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____	<input type="checkbox"/> Doxycycline <input type="checkbox"/> Cipro <input type="checkbox"/> _____
	Dosage	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____	<input type="checkbox"/> 100mg BID <input type="checkbox"/> 500mg BID <input type="checkbox"/> _____
	Labeling	Rx# _____ Lot# _____ NDC# _____ Expiration _____	Rx# _____ Lot# _____ NDC# _____ Expiration _____	Rx# _____ Lot# _____ NDC# _____ Expiration _____	Rx# _____ Lot# _____ NDC# _____ Expiration _____	Rx# _____ Lot# _____ NDC# _____ Expiration _____

Refer to Primary Care Provider Yes No Client Signature: _____

Notes (For Official Use Only):