+Name (Person #1): Last Name _____ First Name _____ M.I. _____

Address Street _____ Apt. # _____ City _____ Zip Code _____

Phone Main # _____ Other # _____ County _____

Official Use Only

TIME IN:
TIME OUT:
☐ Forms Checked

PLEASE PRINT	Person #1	Person #2	Person #3	Person #4	Person #5
LAST NAME: **FIRST NAME:**	**Name Above (Person picking up)**				
BIRTHDATE: **SEX at birth:** **WEIGHT,** only if LESS than 76 pounds**:**	(MM / DD / YYYY) ☐ Male ☐ Female #_____ pounds	(MM / DD / YYYY) ☐ Male ☐ Female #_____ pounds	(MM / DD / YYYY) ☐ Male ☐ Female #_____ pounds	(MM / DD / YYYY) ☐ Male ☐ Female #_____ pounds	(MM / DD / YYYY) ☐ Male ☐ Female #_____ 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

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 ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____
	Dosage	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____
	Labeling	Rx#_____ Lot#_____ NDC#_____	Rx#_____ Lot#_____ NDC#_____	Rx#_____ Lot#_____ NDC#_____	Rx#_____ Lot#_____ NDC#_____	Rx#_____ Lot#_____ NDC#_____

Dispensing Nurse Signature _____

		Expiration _____	Expiration _____	Expiration _____	Expiration _____	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
STOP! Do NOT fill out the information below.						
		Person #6	**Person #7**	**Person #8**	**Person #9**	**Person #10**
Dispenser Initials	Medication	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____
	Dosage	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____
	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):

Dispensing Nurse Signature _____