Person ____: Patient Information If you are picking up medication for this person, all fields are required.

Last Name ____ First Name ____ Birthdate (MM/DD/YYYY) ____ Weight ____

Sex ____

Is this person pregnant? Yes No

Is this person breastfeeding? Yes No

Is this person allergic to: Doxycycline? Yes No Ciprofloxacin? Yes No Amoxicillin? Yes No

Person ____: Patient Information If you are picking up medication for this person, all fields are required.

Last Name ____ First Name ____ Birthdate (MM/DD/YYYY) ____ Weight ____

Sex ____

Is this person pregnant? Yes No

Is this person breastfeeding? Yes No

Is this person allergic to: Doxycycline? Yes No Ciprofloxacin? Yes No Amoxicillin? Yes No

Person ____: Patient Information If you are picking up medication for this person, all fields are required.

Last Name ____ First Name ____ Birthdate (MM/DD/YYYY) ____ Weight ____

Sex ____

Is this person pregnant? Yes No

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Is this person allergic to: Doxycycline? Yes No Ciprofloxacin? Yes No Amoxicillin? Yes No

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Last Name ____ First Name ____ Birthdate (MM/DD/YYYY) ____ Weight ____

Sex ____

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Is this person allergic to: Doxycycline? Yes No Ciprofloxacin? Yes No Amoxicillin? Yes No

Person ____: Patient Information If you are picking up medication for this person, all fields are required.

Last Name ____ First Name ____ Birthdate (MM/DD/YYYY) ____ Weight ____

Sex ____

Is this person pregnant? Yes No

Is this person breastfeeding? Yes No

Is this person allergic to: Doxycycline? Yes No Ciprofloxacin? Yes No Amoxicillin? Yes No

Patient Agreement Statement

When I sign this form, I am agreeing that:

- I was given medical fact sheets and medicine for the people listed on this form. I agree to give the medical fact sheets and medicine to the people listed on this form, and only to those people.
- I understand the purpose of this medicine is to help the people listed on this form to not get sick. But if they still get sick, I understand they should go see a doctor.
- I was given information about the Health Insurance Portability and Accountability Act (HIPAA). I understand my rights.

Person 1 Print Name *

Person 1 Signature *

STOP! Do NOT fill out anything below here. Thank you!

Person ____

Medication	Dosage	Labeling	
Doxycycline	100mg BID	Rx #	NDC #
Ciprofloxacin	500mg BID	Lot #	Expiration
________	________		

Person ____

Medication	Dosage	Labeling	
Doxycycline	100mg BID	Rx #	NDC #
Ciprofloxacin	500mg BID	Lot #	Expiration
________	________		

Person ____

Medication	Dosage	Labeling	
Doxycycline	100mg BID	Rx #	NDC #
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________	________		

Person ____

Medication	Dosage	Labeling	
Doxycycline	100mg BID	Rx #	NDC #
Ciprofloxacin	500mg BID	Lot #	Expiration
________	________		

Person ____

Medication	Dosage	Labeling	
Doxycycline	100mg BID	Rx #	NDC #
Ciprofloxacin	500mg BID	Lot #	Expiration
________	________		

Refer to Primary Care?
Yes No

Dispensing Nurse Initials

Referral Notes:

Patient Referral Signature

Other Notes:

Dispensing Nurse Signature