Emergency Prescription Pick Up Form

Time IN ____________

Time OUT ____________

Forms checked?

Person 1: Contact and Patient Information

All fields marked with a red asterisk (*) are required.

Last Name * ____________ First Name * ____________ Middle Initial * ____________

Address * ____________ City, State, ZIP Code * ____________ County * ____________

Main Phone Number * ____________ Other Phone Number ____________ Birthdate * (MM/DD/YYYY) ____________ Weight * ____________

Sex * ____________ Gender Identity ____________ Pronouns ____________

Are you pregnant? * Yes No

Are you breastfeeding? * Yes No

Are you allergic to Doxycycline? * Yes No

Are you allergic to Ciprofloxacin? * Yes No

Are you allergic to Amoxicillin? * Yes No

Person 2: 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 Person 2 pregnant? Yes No

Is Person 2 breastfeeding? Yes No

Is Person 2 allergic to Doxycycline? Yes No

Is Person 2 allergic to Ciprofloxacin? Yes No

Is Person 2 allergic to Amoxicillin? Yes No

Person 3: 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 Person 3 pregnant? Yes No

Is Person 3 breastfeeding? Yes No

Is Person 3 allergic to Doxycycline? Yes No

Is Person 3 allergic to Ciprofloxacin? Yes No

Is Person 3 allergic to Amoxicillin? Yes No

Person 4: 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 Person 4 pregnant? Yes No

Is Person 4 breastfeeding? Yes No

Is Person 4 allergic to Doxycycline? Yes No

Is Person 4 allergic to Ciprofloxacin? Yes No

Is Person 4 allergic to Amoxicillin? Yes No

Person 5: 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 Person 5 pregnant?
Yes No

Is Person 5 breastfeeding?
Yes No

Is Person 5 allergic to Doxycycline?
Yes No

Is Person 5 allergic to Ciprofloxacin?
Yes No

Is Person 5 allergic to 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 1

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

Person 2

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

Person 3

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

Person 4

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

Person 5

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

Refer to Primary Care?
Yes No

Dispensing Nurse Initials

Referral Notes:

Patient Referral Signature

Other Notes:

Dispensing Nurse Signature