

+Name (Person #1): _____ <div style="display: flex; justify-content: space-between; width: 90%; margin-left: 20px;"> Last Name First Name M.I. </div> Address _____ <div style="display: flex; justify-content: space-between; width: 90%; margin-left: 20px;"> Street Apt. # City Zip Code </div> Phone _____ <div style="display: flex; justify-content: space-between; width: 90%; margin-left: 20px;"> Main # Other # County </div>	Official Use Only TIME IN: TIME OUT: <input type="checkbox"/> Forms Checked
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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:	<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# _____

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:					
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 _____	Rx# _____ Lot# _____ NDC# _____ Expiration _____

Refer to Primary Care Provider Yes No Client Signature: _____

Notes (For Official Use Only):

Dispensing Nurse Signature _____