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

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

Phone Main # _____ Other # _____ County _____

Official Use Only

Distribution Site:

Date:

TIME IN: **TIME OUT:**

PLEASE PRINT	Person #1	Person #2	Person #3	Person #4	Person #5
LAST NAME: **FIRST NAME:**	**Name Above (Person picking up)**				
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 Tetracyclines?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Allergic to Quinolones?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Allergic to Penicillins?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
No Allergies or Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown

Names of Drugs	Tetracycline Drugs		Quinolone Drugs				Penicillin Drugs			
	Doxycycline	Sumycin	Avelox	Floxin	Levafloxacin	Tequin	Amoxicillin	Augmentin	Penicillin	V-Cillin
	Minocin	Tetracycline	Cipro	Gaitfloxacin	Moxifloxacin		Amoxil	Pen VK	Principen	
	Minocycline	Vibramycin	Ciprofloxacin	Levaquin	Ofloxacin		Ampicillin	Pen G	Trimox	

I have been given disease & medicine fact sheets and medicine for people listed on this form. I agree to give them the information and medicine. I understand this medicine is meant to keep us from getting sick. If I or any of them gets sick, or is already sick, we should see a doctor. I have received and understand my HIPAA rights.

Signature (Person #1): _____

STOP! Do NOT fill out the information below.

Dispenser Initials		Person #1	Person #2	Person #3	Person #4	Person #5
	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 _____

Dispensing Nurse Signature _____

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 Tetracyclines?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Allergic to Quinolones?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Allergic to Penicillins?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Allergies Not Known	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown

Names of Drugs	Tetracycline Drugs		Quinolone Drugs				Penicillin Drugs			
	Doxycycline	Sumycin	Avelox	Floxin	Levafloxacin	Tequin	Amoxicillin	Augmentin	Penicillin	V-Cillin
	Minocin	Tetracycline	Cipro	Gaitfloxacin	Moxifloxacin		Amoxil	Pen VK	Principen	
	Minocycline	Vibramycin	Ciprofloxacin	Levaquin	Ofloxacin		Ampicillin	Pen G	Trimox	

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 _____