

Health Assessment Form (FILL OUT THE WHITE SECTIONS)

Your Address: _____ Phone: _____
 City: _____ State: _____ Zip: _____
 Total number of people, including yourself, for whom you are picking up medications? _____

Provide Information On Yourself In The Sections Below.
 If You Are Picking Up Medicines For Others, Then Also
 Fill Out The Back Side Of This Form.

***** For Staff Use Only *****

Person 1: Yourself	Drug Dosage	Initial	Affix Label
First Name: _____	Ciprofloxacin 500 mg PO q 12 hrs		
Last Name: _____	Ciprofloxacin _____ mg PO q 12 hrs		
Age: _____ Weight: _____ pounds	Doxycycline 100 mg PO q 12 hrs		
Are you currently: _____ Circle the Correct Answer	Doxycycline _____ mg PO q 12 hrs		
Pregnant or Breastfeeding? Yes No	Other		
Taking Medicine for Seizures or Epilepsy? Yes No	Drug _____		
Taking Insulin or Other Medicine for Diabetes? Yes No	Dose _____		
Have you ever had: _____ Circle the Correct Answer	Freq _____		
An allergic reaction to any Tetracycline drug? (see the list below) Yes No	Route _____		
An allergic reaction to any Quinolone drug? (see the list below) Yes No			
Seizures or Epilepsy? Yes No			
Kidney Disease or a Decrease in Kidney Function? Yes No			

I consent to the preventive antibiotic treatment as prescribed.

Signature of Person Picking Up Medicines: _____ Date: _____
 Signature of Dispenser: _____ Date: _____

- ➔ A List of **Tetracycline Drugs**
- demeclocycline (Declomycin)
 - doxycycline (Adoxa, Bio-Tab, Doryx, Doxy, Monodox, Periostat, Vibra-Tabs, Vibramycin)
 - minocycline (Arestin, Dynacin, Minocin, Vectrin)
 - oxytetracycline (Terak, Terra-Cortril, Terramycin, Urobiotic-250)
 - tetracycline (Achromycin V, Sumycin, Topicycline, Helidac)
- If there has been an allergic reaction to any of these drugs, circle "Yes" beside the question "An allergic reaction to any Tetracycline drug?". (One or more of the following symptoms can indicate an allergic reaction: skin rash, hives, or itching; wheezing, shortness of breath or trouble breathing; and/or swelling of the face, lips, or throat.)

- ➔ A List of **Quinolone Drugs**
- | | |
|-------------------------------------|--|
| acrosoxacin or rosoxacin (Eradacil) | norfloxacin (Chibroxin, Noroxin) |
| cinoxacin (Cinobac) | nalidixic acid (NegGram) |
| ciprofloxacin (Cipro, Ciloxan) | ofloxacin (Floxin, Ocuflox) |
| gatafloxacin (Tequin) | oxolinic acid |
| grepafloxacin (Raxar) | pefloxacin (Peflacin) |
| levafloxacin (Levaquin, Quixin) | rufloxacin |
| lomefloxacin (Maxaquin) | sparfloxacin (Zagam, Respipac) |
| moxifloxacin (Avelox, ABC Pak) | temafloxacin |
| nadifloxacin (Acuatim) | trovafloxacin or alatrofloxacin (Trovan) |
- If there has been an allergic reaction to any of these drugs, circle "Yes" beside the question "An allergic reaction to any Quinolone drug?". (One or more of the following symptoms can indicate an allergic reaction: skin rash, hives, or itching; wheezing, shortness of breath or trouble breathing; and/or swelling of the face, lips, or throat.)

*This form is a sample only. During any specific event, federal, state and local health officials may supply a slightly different form.

If You Are Picking Up Medicines For Others, Fill Out The Appropriate Sections Below.		***** For Staff Use Only *****		
Person 2: Relationship to you: _____		Drug Dosage	Initial	Affix Label
First Name: _____		Ciprofloxacin 500 mg PO q 12 hrs		
Last Name: _____		Ciprofloxacin _____ mg PO q 12 hrs		
Weight: _____ pounds OR Height: _____ feet _____ inches		Doxycycline 100 mg PO q 12 hrs		
Age: _____		Doxycycline _____ mg PO q 12 hrs		
Is the person currently: Circle the Correct Answer		Other		
Pregnant or Breastfeeding? Yes No		Drug _____		
Taking Medicine for Seizures or Epilepsy? Yes No		Dose _____		
Taking Insulin or Other Medicine for Diabetes? Yes No		Freq _____		
Has the person ever had: Circle the Correct Answer		Route _____		
An allergic reaction to any Tetracycline drug? (see list on the other side of the page) Yes No				
An allergic reaction to any Quinolone drug? (see list on the other side of the page) Yes No				
Seizures or Epilepsy? Yes No				
Kidney Disease or Decreased Kidney Function? Yes No				
Person 3: Relationship to you: _____		Drug Dosage	Initial	Affix Label
First Name: _____		Ciprofloxacin 500 mg PO q 12 hrs		
Last Name: _____		Ciprofloxacin _____ mg PO q 12 hrs		
Weight: _____ pounds OR Height: _____ feet _____ inches		Doxycycline 100 mg PO q 12 hrs		
Age: _____		Doxycycline _____ mg PO q 12 hrs		
Is the person currently: Circle the Correct Answer		Other		
Pregnant or Breastfeeding? Yes No		Drug _____		
Taking Medicine for Seizures or Epilepsy? Yes No		Dose _____		
Taking Insulin or Other Medicine for Diabetes? Yes No		Freq _____		
Has the person ever had: Circle the Correct Answer		Route _____		
An allergic reaction to any Tetracycline drug? (see list on the other side of the page) Yes No				
An allergic reaction to any Quinolone drug? (see list on the other side of the page) Yes No				
Seizures or Epilepsy? Yes No				
Kidney Disease or Decreased Kidney Function? Yes No				
Person 4: Relationship to you: _____		Drug Dosage	Initial	Affix Label
First Name: _____		Ciprofloxacin 500 mg PO q 12 hrs		
Last Name: _____		Ciprofloxacin _____ mg PO q 12 hrs		
Weight: _____ pounds OR Height: _____ feet _____ inches		Doxycycline 100 mg PO q 12 hrs		
Age: _____		Doxycycline _____ mg PO q 12 hrs		
Is the person currently: Circle the Correct Answer		Other		
Pregnant or Breastfeeding? Yes No		Drug _____		
Taking Medicine for Seizures or Epilepsy? Yes No		Dose _____		
Taking Insulin or Other Medicine for Diabetes? Yes No		Freq _____		
Has the person ever had: Circle the Correct Answer		Route _____		
An allergic reaction to any Tetracycline drug? (see list on the other side of the page) Yes No				
An allergic reaction to any Quinolone drug? (see list on the other side of the page) Yes No				
Seizures or Epilepsy? Yes No				
Kidney Disease or Decreased Kidney Function? Yes No				