Household Health Information Form

Answer All Questions Below:

Full Name of Person Picking up Medication:_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ Phone:_____ Date:_____

Provide the name and age of each person for whom you are picking up medication. Answer YES or NO to questions in column A, B, C and D for each person whom you are picking up medication.	**A** **Is the person listed on this line:** • Breastfeeding **OR** • Pregnant	**B** **Is the person listed on this line allergic to** • Doxycycline **OR** • Tetracyclines	**C** **Is the person listed on this line allergic to** • Ciprofloxacin or Quinolones **Or are they taking:** • Tizanadine / Zanaflex **Do they have:** • Myasthenia Gravis	**D** **Does this person weigh less than 99 pounds (lbs):** • If yes, indicate weight below	**To Be Completed By Staff** **Medication Given**	**Label**
1) Self: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	
2) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	
3) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	
4) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	
5) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	

Medical Referral Notes:

(*check one*) Medication was Accepted ❒ or Refused ❒ Patient Signature:

Provide the name and age of each person for whom you are picking up medication. Answer YES or NO to questions in column A, B, C and D for each person whom you are picking up medication.	**A** **Is the person listed on this line:** • Breastfeeding **OR** • Pregnant	**B** **Is the person listed on this line allergic to** • Doxycycline **OR** • Tetracyclines	**C** **Is the person listed on this line allergic to** • Ciprofloxacin or Quinolones **Or are they taking:** • Tizanadine / Zanaflex **Do they have:** • Myasthenia Gravis	**D** **Does this person weigh less than 99 pounds (lbs):** • If yes, indicate weight below	**To Be Completed By Staff**	
					Medication Given	**Label**
6) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	
7) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	
8) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	
9) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	
10) Name: Age:	NO / YES	NO / YES	NO / YES	NO / YES _____LBS	__ Doxy 100mg __ Cipro 500mg __ Crush Instruct __ Liquid Mix Instr __ Med Referral	

Medical Referral Notes:

Fill out additional pages if medication is being picked up for more than 10 people.

Medication Decision Key

	A	B	C	D	
	Is the person listed on this line: • Breastfeeding **OR** • Pregnant	**Is the person listed on this line allergic to** • Doxycycline or Tetracyclines	**Is the person listed on this line allergic to** • Ciprofloxacin or Quinolones **Or are they taking:** • Tizanadine / Zanaflex **Or do they have:** • Myasthenia gravis	**Does this person weigh less than 99 pounds (lbs):** Indicate weight [If "NO", ignore this column in decision-making]	
	Answer A	**Answer B**	**Answer C**	**Answer D***	**Provide**
***** If **YES** is circled in the D column, or if patient is UNABLE TO SWALLOW pills, provide crushing instructions or liquid instructions as appropriate. If **NO** is circled in column D, and patient is able to swallow pills, ignore column D and proceed with decision-making matrix.	No	No	No	**Yes**: provide crushing instructions	Doxy or Cipro (choose primary medication offered in SNS cache received)
	No	No	Yes	**Yes**: provide crushing instructions	Doxy
	No	Yes	No	**Yes**: provide liquid mixing instructions	Cipro
	Yes	No	No	**Yes**: provide liquid mixing instructions	Cipro
	Yes	Yes	No	**Yes**: provide liquid mixing instructions	Cipro
	Yes	No	Yes	**Yes**: provide Medical Referral	Medical Referral
	No	Yes	Yes	**Yes**: provide Medical Referral	Medical Referral
	Yes	Yes	Yes	**Yes**: provide Medical Referral	Medical Referral