Allen County Health Department – Mass Prophylaxis Registration

POD#

PLEASE PRINT IN CAPITAL LETTERS – MARK INSIDE THE BOXES – USE INK

Person 1 LAST NAME | FIRST NAME | MI | BIRTH DATE mm/dd/yyyy / /

ADDRESS

CITY | STATE | ZIP

PHONE - - | COUNTY

You will be Person #1. Use the additional rows below if you are picking up medicine for other individuals.

Person 2 LAST NAME | FIRST NAME | MI | BIRTH DATE mm/dd/yyyy / /

Person 3 LAST NAME | FIRST NAME | MI | BIRTH DATE / /

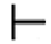
Person 4 LAST NAME | FIRST NAME | MI | BIRTH DATE / /

Person 5 LAST NAME | FIRST NAME | MI | BIRTH DATE / /

	Person 1	Person 2	Person 3	Person 4	Person 5
Weight if less than 90 pounds					
Relationship to you	SELF				
Pregnant?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?
Breast feeding?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?
Do you have seizures?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?
Do you have asthma?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?
Allergies, bad reactions, or side effects to the following:					
Doxycycline or Tetracycline?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?
Ciprofloxacin?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?
Penicillin?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?	○ No ○ Yes ○ ?

STOP **THANK YOU FOR COMPLETING YOUR SIDE OF THE FORM.** STOP

DRAFT



Medical Evaluation: ____

____

____

Disposition: Continue dispensing process for ______________________ medication.

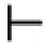
Refer to: ☐ MH Consultation ☐ Treatment Facility ☐ Personal Physician

Health Care Provider Signature: ______________________________

Printed Name: ______________________________

Person 1	Person 2	Person 3	Person 4	Person 5
☐ Doxycycline	☐ Doxycycline	☐ Doxycycline	☐ Doxycycline	☐ Doxycycline
☐ Ciprofloxacin	☐ Ciprofloxacin	☐ Ciprofloxacin	☐ Ciprofloxacin	☐ Ciprofloxacin
☐ Amoxicillin	☐ Amoxicillin	☐ Amoxicillin	☐ Amoxicillin	☐ Amoxicillin
Affix tear-off tab here	Affix tear-off tab here	Affix tear-off tab here	Affix tear-off tab here	Affix tear-off tab here

I have read, or have had explained to me, the information on the Fact Sheets about the disease and medicine. I have had a chance to ask questions and I was satisfied with the answers. I understand the benefits and risks of the medicine. I consent to receive the medicine for myself and other persons named on this form. I will give the information and medicine to those persons listed.



Client Signature: ______________________ Date: ______________

THANK YOU. PLEASE TURN THIS FORM IN WHEN YOU LEAVE.

DRAFT