

HOUSEHOLD ANTIBIOTIC DISPENSING / CONSENT FORM

Instructions: Please fill in the blanks with the requested information and check the correct box for each person in the household you are picking up medicine for. Please list health information for each person or child separately. Use a second form if your household has more than five members. Please print.

Person picking up medicine

Last name: _____ First Name: _____

Address: _____ City: _____

Home phone number: _____ Other phone: _____

Health History/Treatment Information

	Person #1		Person #2		Person #3		Person #4		Person #5	
First Name										
Last Name										
Birth date & Sex	/ /	M F	/ /	M F	/ /	M F	/ /	M F	/ /	M F
If child, please Include weight										
How are you related to each person listed?										
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the person feeling ill?										
Medication allergies?										
Pregnant? Weeks?										
Breast-feeding?										
Organ transplant?										
Hepatitis/Liver Disease?										
Epilepsy/Seizures?										
Dialysis?										
Immunosuppressed?										

If **YES**, please add brief details for each person on the **back of the form**:

List current Rx medications for each person. (Use the back of form if additional space is needed and list which person).

PLEASE LEAVE THIS SECTION BLANK

Medication & Dose Prescribed:	Ciprofloxacin 500mg BID _____ Other Dosage _____	Ciprofloxacin 500mg BID _____ Other dosage _____	Ciprofloxacin 500mg BID _____ Other dosage _____	Ciprofloxacin 500mg BID _____ Other dosage _____	Ciprofloxacin 500mg BID _____ Other dosage _____
Health Screener Initials: _____	Doxycycline 100mg BID _____ Other dosage _____	Doxycycline 100mg BID _____ Other dosage _____	Doxycycline 100mg BID _____ Other dosage _____	Doxycycline 100mg BID _____ Other dosage _____	Doxycycline 100mg BID _____ Other dosage _____
	Amoxicillin 250mg TID _____ Other dosage _____	Amoxicillin 250mg TID _____ Other dosage _____	Amoxicillin 250mg TID _____ Other dosage _____	Amoxicillin 250mg TID _____ Other dosage _____	Amoxicillin 250mg TID _____ Other dosage _____
	Other Dosage _____	Other Dosage _____	Other Dosage _____	Other Dosage _____	Other Dosage _____
Qty Dispensed					
Mfr / Lot #					

I have read or have had explained to me the information on the fact sheets about the disease and medication. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefit and risks of taking the prescribed medication. I consent to receive the medication for myself, my children and other persons in my household and listed on forms. I will share the information with and give the medication to those persons listed.

Signature of the person picking up the medicine: _____ **Date:** _____

Dispensed by: _____ **Date:** _____ **POD Site:** _____

Disposition: Home unless otherwise marked Medical/Isolation Social Ambulance/ER