HEAD OF HOUSEHOLD POST-EXPOSURE PROPHYLAXIS REGISTRATION FORM

Page 1: Start on this Side of the Form

Enter the name and age of each person for whom you are picking up medications.

**** List your name first ****

Circle below for each person

		Drug Allergy to either Doxycycline or Tetracycline ↓	Under 90 lbs ↓	Pregnant ↓	*Shaded Area To Be Completed By Staff*		
1	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No	******* STOP DO NOT WRITE IN SHADED AREA *******	Doxycycline Ciprofloxacin Amoxicillin	SNS Medication Label Here
2	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin Amoxicillin	SNS Medication Label Here
3	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin Amoxicillin	SNS Medication Label Here
4	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin Amoxicillin	SNS Medication Label Here
5	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin Amoxicillin	SNS Medication Label Here
6	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline *Ciprofloxacin* *Amoxicillin*	SNS Medication Label Here

****CONTINUE on back if needed****

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Numbers

Home: ( ) _____

Mobile: ( ) _____

Work: ( ) _____

☐ I am picking up medications for myself. I agree to take them as prescribed.

☐ I am picking up medications for others in my household. I am authorized to sign for these people, and I agree to provide the medications and instructions to all of them.

Signature_____**Date:**_____

****WARNING****

The medications you are picking up today may cause side effects, especially if taken with other medications (either prescription or over-the-counter). Talk to your health care provider if you or anyone in your household is taking other medications.

HEAD OF HOUSEHOLD POST-EXPOSURE PROPHYLAXIS REGISTRATION FORM

Page 2: Fill Out Other Side of the Form First!

Enter the name and age of each person for whom you are picking up medications.

Circle below for each person

		Drug Allergy to either Doxycycline or Tetracycline ↓	Under 90lbs ↓	Pregnant ↓	*Shaded Area To Be Completed By Staff*		
7	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No	******* STOP DO NOT WRITE IN SHADED AREA *******	*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
8	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
9	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
10	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
11	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
12	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
13	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
14	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
15	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*