HEAD OF HOUSEHOLD POST-EXPOSURE PROPHYLAXIS REGISTRATION FORM

		Page 1: Start on this Side of the Form									
	er the name and age of each person for om you are picking up medications.	*Circle below for each person*					TENNESSEE HEALTH				
** List your name first **		Drug Allergy to either Doxycycline or Tetracycline	Under 90 lbs ↓	Pregnant			To Be Completed Staff				
1	Name (Last, First):		V	V	Doxy	oxycycline	SNS Medication Label Here				
	Age:	Yes	Yes	Yes	. Ciı	profloxacin					
	Weight if less than 90 pounds:	No	No	No	*	moxicillin					
	Name (Last, First):	Yes	Yes	Yes	C) De	oxycycline	SNS Medication Label Here				
2	Age:	162			STOP	profloxacin					
	Weight if less than 90 pounds:	No	No	No		moxicillin					
	Name (Last, First):	Yes	Yes	Yes		oxycycline					
3	Age:	100	163	103	O7 Cil	profloxacin	SNS Medication Label Here				
	Weight if less than 90 pounds:	No	No	No	W _Z Aı	moxicillin					
4	Name (Last, First):	Yes	Yes	Yes	NRITE	oxycycline					
	Age:	162	162	res	≷ Ci _l	profloxacin	SNS Medication Label Here				
	Weight if less than 90 pounds:	No	No	No	SH/	moxicillin	11010				
5	Name (Last, First):	Yes	Yes	Yes	40E	oxycycline					
	Age:	100	100	1.00	Ciprofloxacir Amoxicillin		SNS Medication Label Here				
	Weight if less than 90 pounds:	No	No	No							
	Name (Last, First):	Yes	Yes	Yes	‡ De	oxycycline					
6	Age:				Ci	profloxacin	SNS Medication Label Here				
	Weight if less than 90 pounds:	No	No	No	A	moxicillin					
	CONTINUE on I	back if need	ded				Phone Numbers				
Address:							()				
City: State:		Zip Code:				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											

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 F	irst!			
Enter the name and age of each person for whom you are picking up medications.		*Circle b	elow fo	r each po		TENNESSEE HEALTH	
		Drug Allergy to either Doxycycline or Tetracycline	Under 90lbs ↓	Pregnant ↓	Sha		To Be Completed Staff
	Name (Last, First):	Yes	Yes	Yes	D	oxycycline	SNS Medication Label Here
_	Age:	162	162	162	Ci	profloxacin	
7	Weight if less than 90 pounds:	No	No	No	Amoxicillin		
	Name (Last, First):	.,		.,		oxycycline	SNS Medication Label Here
	Age:	Yes	Yes	Yes		profloxacin	
8	Weight if less than 90 pounds:	No	No	No		moxicillin	
	Name (Last, First):				*		
	Age:	Yes	Yes	Yes	*	oxycycline	
9	Weight if less than 90 pounds:	No	No	No		profloxacin	SNS Medication Label Here
	Name (Last, First):				Q -	moxicillin 	
	Age:	Yes	Yes	Yes	0	oxycycline	
10	Weight if less than 90 pounds:	No	No	No			SNS Medication Label Here
	Name (Last, First):	110	110	110	18	moxicillin	
		Yes	Yes	Yes	\mathbf{S}	oxycycline	
11	Age:					profloxacin	SNS Medication Label Here
	Weight if less than 90 pounds:	No	No	No	E A	moxicillin	
	Name (Last, First):	Yes	Yes	Yes	S	oxycycline	SNS Medication Label Here
12	Age:					profloxacin	
	Weight if less than 90 pounds:	No	No	No)ED A	moxicillin	
	Name (Last, First):	Yes	Yes	Yes	4 D	oxycycline	
13	Age:	. 165	No	No	3	profloxacin	SNS Medication Label Here
13	Weight if less than 90 pounds:	No				moxicillin	
	Name (Last, First):	Yes	Yes	Yes	I D	oxycycline	
	Age:					profloxacin	SNS Medication Label Here
14	Weight if less than 90 pounds:	No	No	No		moxicillin	-
15	Name (Last, First):		Yes	Yes		oxycycline	SNS Medication Label Here
	Age:	Yes				profloxacin	
	Weight if less than 90 pounds:	No	No	No		moxicillin	
					A	OXICIIIII	