

V5.1

To be completed by Registration Greeters

1. Personal Identification (please check one) SSN Passport Motor Vehicle License Other _____
2. Have you or anyone in your family/household been informed you were exposed to anthrax? Yes No

**Farmington Valley Health District
Family or Household Screening and Dispensing Form**

FAMILY INFORMATION (To be completed by Head of Household or Person picking up the medication)

Name: (last) _____ (first) _____ (middle) _____

Address: _____ Apt. _____ City _____ State _____ Zip Code _____

Telephone:

Home () _____ - _____ Work () _____ - _____ Cell () _____ - _____

	Person #1		Person #2		Person #3		Person #4		Person #5	
Last Name										
First Name										
Birth Date	/ /		/ /		/ /		/ /		/ /	
Weight - Children										
Relationship to the individual picking up medication										
Now having any of the following?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Trouble catching your breath, recent cough, or chest pain										
Fever, chills, weakness										
Very bad head pain										
Anything new on your skin in the last 2 days										
Sick to your stomach, vomiting, or coughing mucus										
Sores in the mouth or throat										
History of seizure (e.g., epilepsy/fits)?										
Kidney impairment (e.g., dialysis)?										
Liver disease (e.g., hepatitis)?										
Pregnant or breastfeeding?										
Severe allergy to any antibiotics?										
Used any antibiotics in past 10 days?										
Feeling sick today?										

Form reviewed _____

Signature

Do Not Write Below This Line					
Medication & dosage	Ciprofloxacin 500mg BID x 10	Ciprofloxacin 500mg BID x 10	Ciprofloxacin 500mg BID x 10	Ciprofloxacin 500mg BID x 10	Ciprofloxacin 500mg BID x 10
	Cipro Oral Suspension ___mg BID x 10	Cipro Oral Suspension ___mg BID x 10	Cipro Oral Suspension ___mg BID x 10	Cipro Oral Suspension ___mg BID x 10	Cipro Oral Suspension ___mg BID x 10
	Doxycycline 100mg BID x 10	Doxycycline 100mg BID x 10	Doxycycline 100mg BID x 10	Doxycycline 100mg BID x 10	Doxycycline 100mg BID x 10
	Doxy Oral Suspension ___mg BID x 10	Doxy Oral Suspension ___mg BID x 10	Doxy Oral Suspension ___mg BID x 10	Doxy Oral Suspension ___mg BID x 10	Doxy Oral Suspension ___mg BID x 10
Quantity Dispensed					
Manuf/Lot # Expiration Date:	/ /	/ /	/ /	/ /	/ /

Signature of Provider _____

Signature of Pharmacy Personnel Dispensing Medication _____

Consent of Head of Household, or person picking up the medication

Anthrax Medication Information Given

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 the prescribed medication. I consent to receive the medication for myself, my children and other persons named/listed on this form. I will share the information with and distribute the medication to those persons listed.

I do / do not (circle one) consent to treatment at this time.

(Signature of Head of Household, or person picking up the medication)

(Date)

No antibiotic given
(reason)_____

Green – Express Dispensing

Red – Medical Screening/Evaluation/Consult