

**V5.1 Individual Screening and Dispensing Form. Anthrax**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Home Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_ Date of Birth \_\_\_\_\_

Last 4 SS# \_\_\_\_\_

1. Are you feeling sick today?  
 **Yes**       **No**    **If yes, explain** \_\_\_\_\_
  
2. Do you currently have any of the following?  
 **Yes**       **No**    Recent cough, shortness of breath or chest pain  
 **Yes**       **No**    Fever, chills, muscle aches  
 **Yes**       **No**    Severe headaches  
 **Yes**       **No**    New skin lesions  
 **Yes**       **No**    Nausea, vomiting, bloody diarrhea, sputum  
 **Yes**       **No**    Mouth or throat ulcers
  
3. Do you have a history of any of the following?  
 **Yes**       **No**      Seizure  
 **Yes**       **No**      Kidney disease  
 **Yes**       **No**      Liver disease
  
4. Are you pregnant or breast feeding?  
 **Yes**       **No**
  
5. Do you have severe allergies to any of the following medication?  
 **Yes**       **No**    Doxycycline or other Tetracyclines [Declomycin, Vibramycin, Minocin, Sumycin]  
 **Yes**       **No**    Ciprofloxacin or other Quinolones [Tequin, Levaquin, Maxaquin, Avelox, Noroxin, Ofloxacin]  
 **Yes**       **No**    Amoxicillin or other Penicillins [Principen, Penicillin VK]  
 **Yes**       **No**    Other antibiotics Septra, Bactrim, Rifampin
  
6. Are you currently taking any antibiotics?  
 **Yes**       **No**    **If yes, which ones** \_\_\_\_\_
  
7.       **If all responses are No →Go to Express Dispensing**  
 **If any response is Yes →Go to Medical Evaluation**

**Green – Express Dispensing**  
**Yellow – Assisted Dispensing**  
**Red – Medical Evaluation or Support Services**

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**Express Dispensing Station**  
(To be completed by providers)**Information Given** Anthrax       Medication education**Patient CONSENT**

The risk and benefit of the use of antibiotics to prevent disease from exposure to anthrax has been explained to me. I do / do not (circle one) consent to treatment at this time.

\_\_\_\_\_  
**Patient signature/date****Adult**

- Ciprofloxacin 500 mg orally every 12 hours X
- Doxycycline 100 mg orally every 12 hours
- Amoxicillin 500 mg orally every 8 hours

Number of days dispensed     Three days     Ten days     Thirty days     Sixty days**Pediatric**

- Ciprofloxacin 5-7mg/lb.; \_\_\_\_\_ mg ( \_\_\_\_\_ ml's) orally every 12 hours (250mg/5ml)
- Doxycycline 1-2mg/lb.; \_\_\_\_\_ mg ( \_\_\_\_\_ ml's) orally every 12 hours ( 25mg/5ml)
- Amoxicillin 7mg/lb.; \_\_\_\_\_ mg ( \_\_\_\_\_ ml's) orally every 8 hours (250mg/5ml)
- Other \_\_\_\_\_

Number of days dispensed     Three days     Ten days     Thirty days     Sixty days\_\_\_\_\_  
**Signature of dispenser/title**\_\_\_\_\_  
**Date****Green – Express Dispensing****Yellow – Assisted Dispensing****Red – Medical Evaluation or Support Services**