PUBLIC HEALTH NAME ADDRESS AND PERSONAL HISTORY (NAPH) FORM (Revised 5/2012)

Answer All Questions Below:

Full Name of Person Picking up Medication:_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ Phone:_____ Date:_____

Provide the name and age of each person receiving medication. Answer YES or NO to questions A, B, C and D for any person you are picking up medication for.	A **Does this person weigh less than 99 pounds (lbs):** • If yes, indicate weight	B **Is the person listed on this line:** • Breastfeeding • Pregnant	C **Is the person listed on this line allergic to:** • Doxycycline or Tetracyclines	D **Is the person listed on this line allergic to:** • Ciprofloxacin or Quinolones **Or are they taking:** • Tizanadine / Zanaflex **Do they have:** • Myasthenia Gravis	**To Be Completed By Staff** **Medication Given**	**Label**
1) Self: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral	
2) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral	
3) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral	
4) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral	
5) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral	

Medical Referral Notes:

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6) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral
7) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral
8) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral
9) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral
10) Name: Age:	NO / YES _____LBS	NO / YES	NO / YES	NO / YES	__ Doxy 100mg __ Doxy Crush Inst __ Cipro 500mg __ Cipro Liquid Inst __ Med Referral

Medical Referral Notes:

Fill out a second form if medication is being picked up for more than 10 people.

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Prescription Key – For Staff Use Only

	A	B	C	D	
	Does this person weigh less than 99 pounds (lbs):	**Is the person listed on this line:** • Breastfeeding • Pregnant	**Is the person listed on this line allergic to** • Doxycycline or Tetracyclines	**Is the person listed on this line allergic to** • Ciprofloxacin or Quinolones **Or are they taking:** • Tizanadine / Zanaflex **Or do they have:** • Myasthenia gravis	
	Answer A*	**Answer B**	**Answer C**	**Answer D**	**Provide**
***Provide correct instructions if Answer A is YES and/or UNABLE TO SWALLOW.**	**Doxy Crush Inst**	No	No	No	Doxy (or Cipro)
	Doxy Crush Inst	No	No	Yes	Doxy
	Liquid Cipro Inst	No	Yes	No	Cipro
	Liquid Cipro Inst	Yes	No	No	Cipro
	Liquid Cipro Inst	Yes	Yes	No	Cipro
	Med Refer	Yes	No	Yes	Med Refer
	Med Refer	No	Yes	Yes	Med Refer
	Med Refer	Yes	Yes	Yes	Med Refer