_____ HEALTH DEPARTMENT
ANTIBIOTIC DISPENSING FORM

Official Use Only Do Not Write In This Box Date _____
POD _____Time In _____ Out_____

Please Print Household representative picking up medication(s):

Last name _____First name _____ Phone (H)_____ (C)_____
Address _____ City _____State ____ Zip_____ County _____

Fill out the first column for yourself; complete a separate column for each additional household member

	Household representative	Person #2	Person #3	Person #4	Person #5
Last Name(s)					
First Name, Middle Initial					
Birth date & Gender (sex)	/ / M F	/ / M F	/ / M F	/ / M F	/ / M F
Relationship to Household Representative	Self				
Approx weight if under 90 lbs					
Currently taking antibiotics? If yes, name.					
	✓ If Allergic to any	✓ If Allergic to any	✓ If Allergic to any	✓ If Allergic to any	✓ If Allergic to any
Vibramycin (doxycycline) Sumycin (tetracycline) Minocin (minocycline)	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
Cipro (ciprofloxacin) Tequin (gatifloxacin) Levaquin (levofloxacin) Avelox (moxifloxacin) Noroxin (norfloxacin) Floxin (ofloxacin) NegGram (nalidixic acid)	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
Are you allergic to any other antibiotics?	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
Pregnant, breastfeeding, or 8 years old or under	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
✓ If you have any of these conditions or take any of these drugs					
Birth control pills or patch	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
Dilantin (phenytoin) Phenobarbital Tegretol, Carbatrol (carbamazepine) *Accutane* Isotretinoin	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
Probenecid *Benecid* Coumadin *Warfarin*	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
Theophylline *TheoDur*	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
Micronase *Glyburide*	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No
Kidney disease or transplant	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No	___Yes ____No

I have been advised of the possible risks, complications, and anticipated benefits of the recommended treatment and the possible consequences of not taking preventive treatment. I have had a chance to ask questions which were answered to my satisfaction. I have received written information on all of the medications prescribed. If I am picking up medication for household members, I will explain the possible risks and complications to them or their caregivers, share the written information and only distribute medication to those persons listed above.

Signature of representative: _____ Date: _____

If applicable, name and signature of translator: _____

Screener's Signature:
_____

_____

STOP * DO NOT WRITE BEYOND THIS POINT *** STOP**

Recipient	Medication	Dosage	Rx Label
Household Representative ☐ Adult ☐ Child	☐ Doxy ☐ Cipro		
Person #2 ☐ Adult ☐ Child	☐ Doxy ☐ Cipro		
Person #3 ☐ Adult ☐ Child	☐ Doxy ☐ Cipro		
Person #4 ☐ Adult ☐ Child	☐ Doxy ☐ Cipro		
Person #5 ☐ Adult ☐ Child	☐ Doxy ☐ Cipro		

Additional Comments:

Dispenser's Signature: _____