

FOR STAFF USE ONLY: DISPENSING SITE _____

HEALTH DEPARTMENT INFORMATION FORM FOR RECEIVING ANTIBIOTIC PRESCRIPTIONS – **COMPLETE BOTH SIDES**
Provide Information as completely as you can. Supplying contact information below is critical to receiving medication today. All information will be kept confidential.

PRINT CLEARLY USING CAPITAL LETTERS. USE BLUE OR BLACK PEN.

Your First Name															Your Last Name																			
Mailing Address																														Apartment				
City																									State		Zip Code							
Primary Phone										Secondary Phone (optional)										Signature														

I certify that I have obtained and understand information regarding the medication I have been provided here today and the reasons I am being provided a prophylactic antibiotic. I also certify that the information I have provided here both for myself and for others in my household is accurate to the best of my knowledge.

CRI Front of form

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1 List Members Of Household		2 Fill in the box when the column heading is true. Review columns A, B, & C for each household member.			3 DO NOT COMPLETE THIS SECTION			4 Child?	5 DO NOT COMPLETE THIS SECTION
LIST HOUSEHOLD MEMBERS USE A SEPARATE FORM FOR EACH HOUSEHOLD		A	B	C	G	H	I	J	K
<p>You are welcome to pick up medications for anyone for whom you can answer the screening questions listed at right, but you must complete a separate form for each household represented (You may use additional forms as needed).</p> <p>LIST YOUR NAME FIRST</p> <p>First 10 letters of FIRST NAME First 10 letters of LAST NAME</p> <p>S A M P L E S A M P L E</p>		<p>Is pregnant or is a mother who is breastfeeding.</p>	<p>Has been told he or she is allergic to or shouldn't take any of these:</p> <ul style="list-style-type: none"> • Omeprazole (Nasac) • Monoclonal Antibody • Tetracycline (Achromycin, Biopac, En list, Sumycin, Tetracycline, Tetracycline) 	<p>Has been told he or she is allergic to or shouldn't take any of these:</p> <ul style="list-style-type: none"> • Cephalosporin (Cef) • Levofloxacin (Levofloxacin) • Clindamycin (Cleocin) • Metformin (Glucophage) 	<p>DOXY</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p>CIPRO</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p>Medical Assistance Required</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p>Fill in the box if under the age of 10 years or weighs less than 90 lbs.</p>	<p>PRODUCT LABEL</p>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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CRI Back of Form

TOTAL NUMBER OF PRESCRIPTIONS DISPENSED ON THIS FORM _____

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