ADPH Name, Address, Phone & Health (NAPH) History Form

CLIENT:

First Name: ______________________ Last Name: ______________________

Address: ______________________ City: ______________ State: ______ Zip: __________

Home Phone: ______________________ Cell Phone: ______________________

MEDICAL HISTORY/TREATMENT INFORMATION

	Client Name (Named Above)		Person #2		Person #3		Person #4		Person #5	
First Name Last Name										
Sex/Age	M/_____	F/_____	M/_____	F/_____	M/_____	F/_____	M/_____	F/_____	M/_____	F/_____
Weight (if child)										
Relationship to above										
	* YES	NO	* YES	NO	* YES	NO	* YES	NO	* YES	NO
Allergic to Amoxicillin, Doxycycline or Cipro										
Pregnant										
Breastfeeding										
Taking Birth Control										
Tendonitis										
Myasthenia Gravis										
Seizures or Epilepsy/ Taking Seizure Medication										
Taking Theophylline										
Kidney Disease										
Taking Tizanidine (Zanaflex)										
Heart Arrhythmia/QT Prolongation										
Liver Failure										
Diabetes										

DO NOT WRITE IN THIS BOX – DISPENSING STAFF ONLY

	Client	Person #2	Person #3	Person #4	Person #5
Dosages for reconstituted liquid medications **Doxy Liquid** (60 ml) 25mg/5mL or 50mg/5mL **Cipro Liquid** (100 ml) (flavored) 250mg/5mL or 500 mg/5 mL **Amoxicillin** (100 ml) 400mg/5ml	❑ **Doxy Tabs** 100 mg BID ❑ **Doxy Liquid** ___tsp BID ❑ **Cipro Tabs** 500 mg BID ❑ **Cipro Liquid** ___tsp BID ❑ **Amoxicillin Caps** (2) 250 mg TID ❑ **Amoxicillin Liquid** ____ tsp BID	❑ **Doxy Tabs** 100 mg BID ❑ **Doxy Liquid** ___tsp BID ❑ **Cipro Tabs** 500 mg BID ❑ **Cipro Liquid** ___tsp BID ❑ **Amoxicillin Caps** (2) 250 mg TID ❑ **Amoxicillin Liquid** ____ tsp BID	❑ **Doxy Tabs** 100 mg BID ❑ **Doxy Liquid** ___tsp BID ❑ **Cipro Tabs** 500 mg BID ❑ **Cipro Liquid** ___tsp BID ❑ **Amoxicillin Caps** (2) 250 mg TID ❑ **Amoxicillin Liquid** ____ tsp BID	❑ **Doxy Tabs** 100 mg BID ❑ **Doxy Liquid** ___tsp BID ❑ **Cipro Tabs** 500 mg BID ❑ **Cipro Liquid** ___tsp BID ❑ **Amoxicillin Caps** (2) 250 mg TID ❑ **Amoxicillin Liquid** ____ tsp BID	❑ **Doxy Tabs** 100 mg BID ❑ **Doxy Liquid** ___tsp BID ❑ **Cipro Tabs** 500 mg BID ❑ **Cipro Liquid** ___tsp BID ❑ **Amoxicillin Caps** (2) 250 mg TID ❑ **Amoxicillin Liquid** ____ tsp BID
Qty Dispensed / Rx #					
Manufacturer / Lot #					

(1) Express-(E) (2) Drug Utilization Review-(DUR) (3) Triage (4) Family (5) Functional Access Needs

☐ 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 listed on this form. I will share the information with and distribute the medication to those persons listed.

☐ I **refuse** the medication prescribed at this time for myself and those persons listed.

____
Signature of person picking up the medication

____
Date

______________________ ______________________ ______________________ __________
Dispensed By (PRINT) **Signature** **Location/Site** **Date**