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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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