

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

**Client: (print)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Medical History/Treatment Information**

*LIST ALL "YES" answers in red ink.	Client (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 Family Representative										
	*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 Dialysis										

☐ 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 the person picking up the medication \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT WRITE IN THIS BOX-DISPENSING STAFF USE ONLY**

Dosages for reconstituted liquid medications = <b>Doxy Liquid</b> (60 ml) 25mg/5mL - or 50mg/5 mL <b>Cipro Liquid</b> (100 ml) (flavored) 250mg/5mL or 500 mg/5 mL <b>Amoxicillin</b> (100 ml) 400mg/5ml	<input type="checkbox"/> <b>Doxy Tabs</b> 100 mg BID <input type="checkbox"/> <b>Doxy Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Cipro Tabs</b> 500 mg BID <input type="checkbox"/> <b>Cipro Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Amoxicillin Caps</b> (2) 250 mg TID <input type="checkbox"/> <b>Amoxicillin Liquid</b> ____ tsp BID	<input type="checkbox"/> <b>Doxy Tabs</b> 100 mg BID <input type="checkbox"/> <b>Doxy Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Cipro Tabs</b> 500 mg BID <input type="checkbox"/> <b>Cipro Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Amoxicillin Caps</b> (2) 250 mg TID <input type="checkbox"/> <b>Amoxicillin Liquid</b> ____ tsp BID	<input type="checkbox"/> <b>Doxy Tabs</b> 100 mg BID <input type="checkbox"/> <b>Doxy Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Cipro Tabs</b> 500 mg BID <input type="checkbox"/> <b>Cipro Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Amoxicillin Caps</b> (2) 250 mg TID <input type="checkbox"/> <b>Amoxicillin Liquid</b> ____ tsp BID	<input type="checkbox"/> <b>Doxy Tabs</b> 100 mg BID <input type="checkbox"/> <b>Doxy Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Cipro Tabs</b> 500 mg BID <input type="checkbox"/> <b>Cipro Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Amoxicillin Caps</b> (2) 250 mg TID <input type="checkbox"/> <b>Amoxicillin Liquid</b> ____ tsp BID	<input type="checkbox"/> <b>Doxy Tabs</b> 100 mg BID <input type="checkbox"/> <b>Doxy Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Cipro Tabs</b> 500 mg BID <input type="checkbox"/> <b>Cipro Liquid</b> ____ tsp BID <input type="checkbox"/> <b>Amoxicillin Caps</b> (2) 250 mg TID <input type="checkbox"/> <b>Amoxicillin Liquid</b> ____ tsp BID
Qty Dispensed/ Rx #					
Manufacturer/Lot#					

Dispensed by (print) \_\_\_\_\_ Date \_\_\_\_\_ Location/Site \_\_\_\_\_

Signature \_\_\_\_\_