

**POD Head of Household Form**

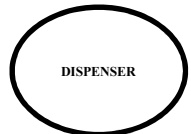
Total Dispensed:
------------------

Name _____ Phone _____ Address _____ City _____ State _____ Zip _____ Email address _____ Emergency Contact _____ Phone _____	I will receive medication fact sheets with the antibiotics dispensed to me. I will read or have had read/explained to me the information about the biological agent and the antibiotics. I will call the Health department (317-392-6470) about any questions I have. I understand the risks and benefits of the recommended medication. I consent to receive the medication for myself, my family and friends listed below. I will share the fact sheets and information and give the medication I received to the persons listed below.  Signature _____ Date _____
--	---

1. List all family and friends for who you are picking up medication, placing your name first.
2. For each person, answer all questions.

NAME	AGE	PREGNANT OR BREASTFEEDING?		REACTION TO DOXYCYCLINE?		REACTION TO CIPROFLOXACIN?		IS THIS PERSON CURRENTLY ON DIALYSIS?		LESS THAN 99 LBS?		<b>DO NOT WRITE PAST THIS SECTION</b>	CHECK MEDICATION SELECTED		AFFIX LABEL
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
1		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
2		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
3		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
4		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
5		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
6		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	

NOTES:



**POD Head of Household Form**

Total Dispensed:
------------------

NAME	AGE	PREGNANT OR BREASTFEEDING?		REACTION TO DOXYCYCLINE?		REACTION TO CIPROFLOXACIN?		IS THIS PERSON CURRENTLY ON DIALYSIS?		LESS THAN 99 LBS?		CHECK MEDICATION SELECTED	AFFIX LABEL	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
7		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
8		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
9		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
10		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
11		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	
12		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	<input type="checkbox"/> Doxy	<input type="checkbox"/> Cipro	

**DO NOT WRITE PAST THIS SECTION**

NOTES:

