

PUBLIC HEALTH NAME ADDRESS AND PERSONAL HISTORY (NAPH) FORM (Revised 5/2016)



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 for whom you are picking up medication.

A	B	C	D
Is the person allergic to: • Doxycycline or Tetracyclines	Is the person allergic to: • Ciprofloxacin or Quinolones Or are they taking: • Tizanadine (Zanaflex) Or do they have: • Myasthenia Gravis	Is the person: • A Breastfeeding Mother • Pregnant	Does this person weigh less than 76 pounds (lbs): • If yes, indicate weight

To Be Completed By Staff	
Medication Given	Label
<input type="checkbox"/> Doxy 100mg <input type="checkbox"/> Doxy & Crush Inst <input type="checkbox"/> Cipro 500mg Cipro Liquid & Inst <input type="checkbox"/> Med Referral	
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<input type="checkbox"/> Doxy 100mg <input type="checkbox"/> Doxy & Crush Inst <input type="checkbox"/> Cipro 500mg Cipro Liquid & Inst <input type="checkbox"/> Med Referral	

1) Yourself:

 Age: _____ Gender: M F

2) Name:

 Age: _____ Gender: M F

3) Name:

 Age: _____ Gender: M F

4) Name:

 Age: _____ Gender: M F

5) Name:

 Age: _____ Gender: M F

Medical Referral Notes:

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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	B	C	D	To Be Completed By Staff	
	Is the person listed on this line allergic to: • Doxycycline or Tetracyclines	Is the person listed on this line allergic to: • Ciprofloxacin or Quinolones Or are they taking: • Tizanadine (Zanaflex) Do they have: • Myasthenia Gravis	Is the person listed on this line: • A Breastfeeding Mother • Pregnant	Does this person weigh less than 76 pounds (lbs): • If yes, indicate weight	Medication Given	Label
6) Name: _____ _____ Age: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ lbs	<input type="checkbox"/> Doxy 100mg <input type="checkbox"/> Doxy & Crush Inst <input type="checkbox"/> Cipro 500mg Cipro Liquid & Inst <input type="checkbox"/> Med Referral	
7) Name: _____ _____ Age: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ lbs	<input type="checkbox"/> Doxy 100mg <input type="checkbox"/> Doxy & Crush Inst <input type="checkbox"/> Cipro 500mg Cipro Liquid & Inst <input type="checkbox"/> Med Referral	
8) Name: _____ _____ Age: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ lbs	<input type="checkbox"/> Doxy 100mg <input type="checkbox"/> Doxy & Crush Inst <input type="checkbox"/> Cipro 500mg Cipro Liquid & Inst <input type="checkbox"/> Med Referral	
9) Name: _____ _____ Age: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ lbs	<input type="checkbox"/> Doxy 100mg <input type="checkbox"/> Doxy & Crush Inst <input type="checkbox"/> Cipro 500mg Cipro Liquid & Inst <input type="checkbox"/> Med Referral	
10) Name: _____ _____ Age: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ lbs	<input type="checkbox"/> Doxy 100mg <input type="checkbox"/> Doxy & Crush Inst <input type="checkbox"/> Cipro 500mg Cipro Liquid & Inst <input type="checkbox"/> Med Referral	

Medical Referral Notes:

Fill out a second form if medication is being picked up for more than 10 people.

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Prescription Key – For Staff Use Only

A	B	C	D
<p>Is the person listed on this line allergic to</p> <ul style="list-style-type: none"> • Doxycycline or Tetracyclines 	<p>Is the person listed on this line allergic to</p> <ul style="list-style-type: none"> • Ciprofloxacin or Quinolones <p>Or are they taking:</p> <ul style="list-style-type: none"> • Tizanadine (Zanaflex) <p>Or do they have:</p> <p>Myasthenia gravis</p>	<p>Is the person listed on this line:</p> <ul style="list-style-type: none"> • Breastfeeding • Pregnant 	<p>Does this person weigh less than 76 pounds (lbs):</p> <ul style="list-style-type: none"> • If yes, indicate weight • If person indicates they are unable to swallow pills, provide crushing instructions

	Answer A	Answer B	Answer C	Answer D* YES only	Provide
<p>*If answer to column D is YES (weights less than 76 lbs) Provide correct instructions (i.e., Doxy Crush Inst., Liquid Cipro Inst., Med Refer.</p> <p>If answer to column D is: NO (does not weigh less than 76 lbs) or does not need a Med Ref, just provide the agent and medication fact sheets; do not provide additional fact sheets.</p>	No	No	No	Doxy Crush Inst	Doxy (or Cipro)
	No	Yes	No	Doxy Crush Inst	Doxy
	Yes	No	No	Liquid Cipro Inst	Cipro
	No	No	Yes	Liquid Cipro Inst	Cipro
	Yes	No	Yes	Liquid Cipro Inst	Cipro
	No	Yes	Yes	Med Refer	Med Refer
	Yes	Yes	No	Med Refer	Med Refer
	Yes	Yes	Yes	Med Refer	Med Refer