Appendix A Mass Prophylaxis Screening Form
NAME – ADDRESS – PHONE – HEALTH HISTORY

Sections I thru IV – To be completed by individual obtaining medications

Date: _____ Site: _____ City: _____ County: _____

SECTIONS I & II RECEPTION

I. INFORMATION (person picking up medications)

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (H) _____ (W) _____ (C) _____

Date of Birth _____

Family Members (include last name if different from yours)

	Name	**DOB**	**Age**	
1	(you)			
2				
3				
4				
5				
6				
7				
8				

II. ACKNOWLEDGEMENT/CONSENT (person picking up medications)

I am picking up medications for myself and/or others that live in my household or for someone who is unable to pick up their own medications. **NO ONE IN MY RESIDENCE IS RECEIVING ADDITIONAL MEDICATIONS AT OTHER SITES.** I am seeking medication in accordance with Centers for Disease Control (CDC) guidelines and the state and county health department. I have received information about the disease and medications. I consent to take the medications.

Signature _____ Date _____

SECTION III – REGISTRATION REVIEW

III. HISTORY of <u>all</u> household members

1. Does anyone have impaired renal function (kidney disease)? Y N Who? _____
2. Do you have children (under 13 or any persons under 90 pounds? Y N Who? _____
3. Is anyone pregnant or breastfeeding? Y N Who? _____
4. Is anyone allergic to the following antibiotics:
   - Penicillin/Amoxicillin? Y N Who? _____
   - Cipro/Levaquin/Fluoroquinolones? Y N Who? _____
   - Doxycycline/Tetracycline? Y N Who? _____
   - Zithromax? Y N Who? _____
   - Rifampin? Y N Who? _____
   - Cephalexin (Keflex)/Cephalosporins? Y N Who? _____

IV. CURRENT MEDICATIONS
Referring to all household members, are any currently taking:

Coumadin (warfarin – blood thinner)	Y	N	Who?	_____
Oral contraceptives (birth control pills) or patch	Y	N	Who?	_____
Theophylline (Theo-Dur, Theo-24 - for asthma)	Y	N	Who?	_____
Antacids or multivitamins	Y	N	Who?	_____
Dilantin (phenytoin – for seizures)	Y	N	Who?	_____
Oral anti-diabetic medications	Y	N	Who?	_____
Methotrexate	Y	N	Who?	_____
Digoxin	Y	N	Who?	_____
Cyclosporine	Y	N	Who?	_____

SECTION IV – REGISTRATION REVIEW

V. INTERVENTIONS (check box in Section I for patients receiving standard therapy)

Name	Weight (if less than 90)	Medication Dispensed (include SIG)	Quantity Dispensed (tabs or mls)

TO BE COMPLETED BY PHARMACIST ONLY

VI. COUNSELING NOTES:

PHYSICIAN FOLLOW UP RECOMMENDED?

RPh initials:

Report to Dispensing Area A B