

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	B	C	D
Does this person weigh less than 99 pounds (lbs): • If yes, indicate weight	Is the person listed on this line: • Breastfeeding • Pregnant	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

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

1) Self:

 Age: _____

NO / YES
 _____ LBS
 NO / YES
 NO / YES
 NO / YES

2) Name:

 Age: _____

NO / YES
 _____ LBS
 NO / YES
 NO / YES
 NO / YES

3) Name:

 Age: _____

NO / YES
 _____ LBS
 NO / YES
 NO / YES
 NO / YES

4) Name:

 Age: _____

NO / YES
 _____ LBS
 NO / YES
 NO / YES
 NO / YES

5) Name:

 Age: _____

NO / YES
 _____ LBS
 NO / YES
 NO / YES
 NO / YES

Medical Referral Notes:

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6) Name: _____ _____ Age: _____ _____ LBS	NO / YES ____ LBS	NO / YES	NO / YES	NO / YES														
7) Name: _____ _____ Age: _____ _____ LBS	NO / YES ____ LBS	NO / YES	NO / YES	NO / YES														
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10) Name: _____ _____ Age: _____ _____ LBS	NO / YES ____ LBS	NO / YES	NO / YES	NO / YES														

Medical Referral Notes:

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

Prescription Key – For Staff Use Only

A	B	C	D
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	Answer A*	Answer B	Answer C	Answer D	Provide
*Provide correct instructions if Answer A is YES and/or UNABLE TO SWALLOW.	Doxy Crush Inst	No	No	No	Doxy (or Cipro)
	Doxy Crush Inst	No	No	Yes	Doxy
	Liquid Cipro Inst	No	Yes	No	Cipro
	Liquid Cipro Inst	Yes	No	No	Cipro
	Liquid Cipro Inst	Yes	Yes	No	Cipro
	Med Refer	Yes	No	Yes	Med Refer
	Med Refer	No	Yes	Yes	Med Refer
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