Instructions:
1. Print full name of each person for whom you are picking up medication. (Your name goes in row 1.)
2. Complete Columns A-E for each person by placing an x in any box in column A-E if appropriate, otherwise leave blank.
3. Give your completed form to a Screening staff member.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

By signing below, I am authorized to sign for these people and I agree to provide the prescribed medications and instructions to each of them.
I understand this medication is meant to keep us from getting sick. If I, or any of them, get sick or is already sick we should seek medical attention.

Name: Signature:

Street Address, City, State, & Zip Code:

Phone Number:

Place an x in any box in column A-E if the statement is true, otherwise leave blank.			A	B	C	D	E	F	Clinic Use Only				
			Doxycycline Contraindications		Ciprofloxacin Contraindications		Amoxicillin Contraindications						
PRINT FULL NAME FOR EACH PERSON (Your name goes in row 1.)	Age	Date of Birth	Allergic to Doxycycline or Tetracycline	Pregnant or Breast-Feeding	Are you taking Tizanidine	ALLERGY to Ciprofloxacin or Quinolone	Allergy to Penicillin	Weighs 88 pounds or less, or has Difficulty Swallowing	**Doxycyline**	**Ciprofloxacin**	**Amoxicillin**	**Referral**	Affix Medication Label Below
1		/ /											
2		/ /											
3		/ /											
4		/ /											
5		/ /											
6		/ /											
7		/ /											
8		/ /											
9		/ /											
10		/ /											
Tetracycline Drugs: Doxycycline, Minocin, Minocycline, Sumycin, Tetracycline, Vibramycin													Total Bottles
Quinolone Drugs: Avelox, Ciprofloxacin, Floxin, Gatifloxacin, Levaquin, Levofloxacin, Moxifloxacin, Ofloxacin, Tequin													

Clinical Consultant's Notes - See attached medication disclaimer form

Dispenser's Initials

Date