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:**_____

Ohio Department of Health

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** **Is the person allergic to:** • Doxycycline or Tetracyclines	**B** **Is the person allergic to:** • Ciprofloxacin or Quinolones **Or are they taking:** • Tizanadine (Zanaflex) **Or do they have:** • Myasthenia Gravis	**C** **Is the person:** • A Breastfeeding Mother • Pregnant	**D** **Does this person weigh less than 76 pounds (lbs):** • If yes, indicate weight	**To Be Completed By Staff** **Medication Given**	**Label**
1) Yourself: _____ _____ Age:_____ Gender: ☐ M ☐ F	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes _____lbs	☐ Doxy 100mg ☐ Doxy & Crush Inst ☐ Cipro 500mg Cipro Liquid & Inst ☐ Med Referral	
2) Name: _____ _____ Age:_____ Gender: ☐ M ☐ F	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes _____lbs	☐ Doxy 100mg ☐ Doxy & Crush Inst ☐ Cipro 500mg Cipro Liquid & Inst ☐ Med Referral	
3) Name: _____ _____ Age:_____ Gender: ☐ M ☐ F	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes _____lbs	☐ Doxy 100mg ☐ Doxy & Crush Inst ☐ Cipro 500mg Cipro Liquid & Inst ☐ Med Referral	
4) Name: _____ _____ Age:_____ Gender: ☐ M ☐ F	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes _____lbs	☐ Doxy 100mg ☐ Doxy & Crush Inst ☐ Cipro 500mg Cipro Liquid & Inst ☐ Med Referral	
5) Name: _____ _____ Age:_____ Gender: ☐ M ☐ F	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes _____lbs	☐ Doxy 100mg ☐ Doxy & Crush Inst ☐ Cipro 500mg Cipro Liquid & Inst ☐ Med Referral	

Medical Referral Notes:

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

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

Medical Referral Notes:

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

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

Prescription Key – For Staff Use Only

A	B	C	D
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) **Or do they have:** Myasthenia gravis	**Is the person listed on this line:** • Breastfeeding • Pregnant	**Does this person weigh less than 76 pounds (lbs):** • 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
*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. 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.	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