POD Site: **Date:**

MEDICAL COUNTERMEASURE DATA COLLECTION FORM

1	Last Name:	First Name:		Middle Initial:	Phone 1:
2	Home Address:	City:	State: IL	Zip code:	Phone 2:

3 Household Members	Self	Person # 2	Person # 3	Person # 4	Person # 5	Person # 6
First Name						
Last Name						
4 Allergic to Doxycycline *or any tetracycline*	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Allergic to Ciprofloxacin or any quinolone	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
5 Weight under 89 pounds or cannot swallow pills	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
6 Pregnant or Breastfeeding	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
7 Taking Zanaflex (tizanidine) History of Myasthenia Gravis and/or Kidney Disease/Dialysis	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

8 I have answered all questions on this form to the best of my ability. I understand this medication is for preventative purposes. I understand the benefits and risks of the medications and know where to access more information. I consent to receive the medications for all individual(s) on this form. I will share the medication(s) and information with the individual(s) named above. I will call my healthcare provider with any questions, problems, and/or concerns.

Signature _____ Date: _____

DO NOT WRITE IN THIS BOX- AUTHORIZED STAFF ONLY

9	Self	Person # 2	Person # 3	Person # 4	Person # 5	Person # 6
FOR SCREENER USE ONLY *Screening Staff Initials:*	DOXY ONLY	DOXY ONLY	DOXY ONLY	DOXY ONLY	DOXY ONLY	DOXY ONLY
	CIPRO ONLY	CIPRO ONLY	CIPRO ONLY	CIPRO ONLY	CIPRO ONLY	CIPRO ONLY
	DOXY or CIPRO	DOXY or CIPRO	DOXY or CIPRO	DOXY or CIPRO	DOXY or CIPRO	DOXY or CIPRO
	MEDICAL CONSULT	MEDICAL CONSULT	MEDICAL CONSULT	MEDICAL CONSULT	MEDICAL CONSULT	MEDICAL CONSULT
FOR MED CONSULT USE ONLY *If applicable Medical Consult Initials:*	DOXY CIPRO	DOXY CIPRO	DOXY CIPRO	DOXY CIPRO	DOXY CIPRO	DOXY CIPRO
	Other:	Other:	Other:	Other:	Other:	Other:
FOR DISPENSER USE ONLY *Dispenser Initials:*	**Place Rx Label**	**Place Rx Label**	**Place Rx Label**	**Place Rx Label**	**Place Rx Label**	**Place Rx Label**

********** TEAR LINE **********

NFORMATION FOR HOUSEHOLD

Please Enter Household Member(s) Name(s) in the Same Order as Indicated Above

Household Members	Self	Person # 2	Person # 3	Person # 4	Person # 5	Person # 6
First Name						
Last Name						
Medication	**Place Rx Label**	**Place Rx Label**	**Place Rx Label**	**Place Rx Label**	**Place Rx Label**	**Place Rx Label**

If a person under 89lbs or cannot swallow pills, refer to the emergency medication dosage chart on crushing form(s).
Do not stop taking this medication without first consulting a physician, or unless directed to do so by public health officials.

If you have any questions, please contact your healthcare provide or DeKalb County Health Department 815-758-6673.
Call 911 if you experience signs of a severe reaction or suspected anaphylaxis after taking medication.

Print Form