Medication Screening Form
DeKalb County Health Department

Your Name: (Please print)
Address: City: Zip Code:
Phone #: Alternate #:

List household members you are picking up medication for, including yourself

A	B	C
Is this person: • Pregnant, or • Breastfeeding, or • Under 9 years old	**Is this person allergic to or shouldn't take any of these:** • doxycyline • minocycline • tetracycline • any '-mycin'	**Is this person:** • Allergic to Ciprofloxacin • Have seizures • On dialysis or have kidney disease • Take blood thinner medications • Currently taking Zanaflex (tizanidine)

STAFF USE ONLY

Box A	Box B	Box C	GIVE
No	No	No	Doxy
No	No	Yes	Doxy
Yes	No	Yes	Doxy
Yes	No	No	Cipro
Yes	Yes	No	Cipro
No	Yes	No	Cipro
No	Yes	Yes	Other
Yes	Yes	Yes	Other

Name (First and Last)	Age	Check **Yes** or **No**	Check **Yes** or **No**	Check **Yes** or **No**	**STAFF USE ONLY** **Give Medication Circled**		
1.Yourself:		Yes No	Yes No	Yes No	Doxy	Cipro	Other
2.		Yes No	Yes No	Yes No	Doxy	Cipro	Other
3.		Yes No	Yes No	Yes No	Doxy	Cipro	Other
4.		Yes No	Yes No	Yes No	Doxy	Cipro	Other
5.		Yes No	Yes No	Yes No	Doxy	Cipro	Other
6.		Yes No	Yes No	Yes No	Doxy	Cipro	Other
STAFF USE ONLY- Add TOTALS Under Doxy & Cipro columns ⇒							

Circle: **D**oxy or **C**ipro	**Patient 1** **D C**	**Patient 2** **D C**	**Patient 3** **D C**	**Patient 4** **D C**	**Patient 5** **D C**	**Patient 6** **D C**
Affix Medication Label Here						

Screener's Initials Here: ____________________