Medication Center Check-in Form

FILL OUT completely to receive your medicine. Please PRINT.

Street address:	City/State/Zip:	Phone 1: Phone 2:

Provide information for yourself and each individual for whom you are picking up medicine.

	YOU	Individual 2	Individual 3
1) The medicine is for: (First, Middle Initial, Last)			
2) Age			
3) Birthdate			
4) Weight (If under 100 pounds)			
5) Is the individual **ALLERGIC** to one or more of these drugs? Doxycycline (Vibramycin) Tetracycline (Sumycin) Minocycline (Minocin)	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐
6) Is the individual **ALLERGIC** to one or more of these drugs? Ciprofloxacin (Cipro) Levofloxacin (Levaquin) Ofloxacin (Floxin)	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐
7) Is the individual **PREGNANT or BREASTFEEDING?**	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐
8) Is the individual on **KIDNEY DIALYSIS?**	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐
9) Is the individual **TAKING** one or more of these drugs? Coumadin (Warfarin) Theophylline (Theo-Dur) Probencid	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐

Dispensing Staff Only: Check box if "Adult Standard" or indicate dose if child. Adhere label.

	YOU	Individual 2	Individual 3
Doxycycline			
Ciprofloxacin			
Amoxicillin			

Staff Use Only

Public Health
Seattle & King County

Medication Center Check-in Form

	Individual 4	Individual 5	Individual 6
1) The medicine is for: (First, Middle Initial, Last)			
2) Age			
3) Weight (If under 100 pounds)			
4) Is the individual **ALLERGIC** to one or more of these drugs? Doxycycline (Vibramycin) Tetracycline (Sumycin) Minocycline (Minocin)	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐
5) Is the individual **ALLERGIC** to one or more of these drugs? Ciprofloxacin (Cipro) Levofloxacin (Levaquin) Ofloxacin (Floxin)	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐
6) Is the individual **PREGNANT or BREASTFEEDING?**	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐
7) Is the individual on **KIDNEY DISEASE/PROPLEMS?**	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐
8) Is the individual **TAKING** one or more of these drugs? Coumadin (Warfarin) Theophylline (Theo-Dur) Probencid	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐	**Yes** ☐ **No** ☐ **Don't Know** ☐

Dispensing Staff Only: **Check box if "Adult Standard" or indicate dose if child.** **Adhere label.**

	YOU	Individual 2	Individual 3
Doxycycline			
Ciprofloxacin			
Amoxicillin			

Staff Use Only