Appendix A Mass Prophylaxis Screening Form
NAME – ADDRESS – PHONE – HEALTH HISTORY

Sections I thru IV – To be completed by individual obtaining medications

Date: ___________ Site: _______________ City: _______________ County: _______________

I. INFORMATION (person picking up medications)

Last Name ___________________________  First Name ___________________________
Address _______________________________________________________________
City ___________________ State ___________ Zip Code __________________________
Phone (H) __________________ (W) ___________ (C) _______________
Date of Birth ___________________________

Family Members (include last name if different from yours)

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<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
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II. ACKNOWLEDGEMENT/CONSENT (person picking up medications)

I am picking up medications for myself and/or others that live in my household or for someone who is unable to pick up their own medications. **NO ONE IN MY RESIDENCE IS RECEIVING ADDITIONAL MEDICATIONS AT OTHER SITES.** I am seeking medication in accordance with Centers for Disease Control (CDC) guidelines and the state and county health department. I have received information about the disease and medications. I consent to take the medications.

Signature ___________________________ Date __________

III. HISTORY of all household members

1. Does anyone have impaired renal function (kidney disease)? Y N Who? ______________________
2. Do you have children (under 13 or any persons under 90 pounds)? Y N Who? ______________________
3. Is anyone pregnant or breastfeeding? Y N Who? ______________________
4. Is anyone allergic to the following antibiotics:
   - Penicillin/Amoxicillin? Y N Who? ______________________
   - Cipro/Levaquin/Fluoroquinolones? Y N Who? ______________________
   - Doxycycline/Tetracycline? Y N Who? ______________________
   - Zithromax? Y N Who? ______________________
   - Rifampin? Y N Who? ______________________
   - Cephalexin (Keflex)/Cephalosporins? Y N Who? ______________________
Appendix A Mass Prophylaxis Screening Form

IV. CURRENT MEDICATIONS
Referring to all household members, are any currently taking:

- Coumadin (warfarin – blood thinner) Y N Who?
- Oral contraceptives (birth control pills) or patch Y N Who?
- Theophylline (Theo-Dur, Theo-24 - for asthma) Y N Who?
- Antacids or multivitamins Y N Who?
- Dilantin (phenytoin – for seizures) Y N Who?
- Oral anti-diabetic medications Y N Who?
- Methotrexate Y N Who?
- Digoxin Y N Who?
- Cyclosporine Y N Who?

V. INTERVENTIONS (check box in Section I for patients receiving standard therapy)

<table>
<thead>
<tr>
<th>Name</th>
<th>Weight (if less than 90)</th>
<th>Medication Dispensed (include SIG)</th>
<th>Quantity Dispensed (tabs or mls)</th>
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VI. COUNSELING NOTES:

PHYSICIAN FOLLOW UP RECOMMENDED? RPh initials:

Report to Dispensing Area A B