Grundy County Health Department

MEDICAL COUNTERMEASURE DATA COLLECTION FORM

Last Name	First Name	Middle Name	Phone 1

Home Address	City	State	Zip	Email

Household members	**SELF** ☐ **Male** ☐ **Female**		**PERSON #2** ☐ **Male** ☐ **Female**		**PERSON #3** ☐ **Male** ☐ **Female**		**PERSON #4** ☐ **Male** ☐ **Female**		**PERSON #5** ☐ **Male** ☐ **Female**	
First Name										
Last Name										
Is/Does household member:	Check ***YES*** if ***ANY*** apply		*Check **YES** if **ANY** apply*		Check ***YES*** if ***ANY*** apply		Check ***YES*** if ***ANY*** apply		Check ***YES*** if ***ANY*** apply	
A • Allergic to Doxycycline *or any tetracycline* • Pregnant • Breastfeeding	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
B • Allergic to Ciprofloxacin *or any quinolone* • Weight under 89 pounds • Unable to swallow a pill • Kidney Disease/Dialysis • History of Myasthenia Gravis • Taking Zanaflex (tizanidine)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

I have answered all questions on this form to the best of my ability. I understand the benefits and risks of the medications and know where to access more information. I consent to receive the medications for all individuals listed on this form. I will share the medication and information with the individual(s) named above. I will call my healthcare provider with any questions, problems, and/or concerns. I understand this medication is intended for PREVENTATIVE PURPOSES ONLY and is not meant to treat illness. I will convey this information to those receiving medication.

Signature: _____ *Date:* _____

DO NOT WRITE IN THIS BOX - FOR STAFF USE ONLY

	SELF	**PERSON #2**	**PERSON #3**	**PERSON #4**	**PERSON #5**
For **SCREENER** use ONLY Screening staff initials	**Doxy Only** **Cipro Only** **Doxy or Cipro** **Medical Consult**	**Doxy Only** **Cipro Only** **Doxy or Cipro** **Medical Consult**	**Doxy Only** **Cipro Only** **Doxy or Cipro** **Medical Consult**	**Doxy Only** **Cipro Only** **Doxy or Cipro** **Medical Consult**	**Doxy Only** **Cipro Only** **Doxy or Cipro** **Medical Consult**
For **MEDICAL CONSULT** use ONLY If applicable - med consult initials	**DOXY** **CIPRO** **OTHER**	**DOXY** **CIPRO** **OTHER**	**DOXY** **CIPRO** **OTHER**	**DOXY** **CIPRO** **OTHER**	**DOXY** **CIPRO** **OTHER**
For **DISPENSER** use ONLY Dispenser initials	**Place RX Label(s)**	**Place RX Label(s)**	**Place RX Label(s)**	**Place RX Label(s)**	**Place RX Label(s)**
Date:	Site Location (Circle): **INSERT INITIALS OF EACH SITE**				

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

INFORMATION 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**
First Name					
Last name					
Medication	**Place RX Label**	**Place RX Label**	**Place RX Label**	**Place RX Label**	**Place RX Label**

If person under 89 lbs. 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 provider or:
Grundy County Health Department at (815) 941-3400, or the
Call 911 if you experience signs of severe reaction or suspected anaphylaxis after taking medication.