



## ANTHRAX PROPHYLAXIS REGISTRATION FORM

**Miami-Dade County Health Department. Call 24 hours a day at (305) 470-5660**



POD # \_\_\_\_\_

Date: \_\_\_\_\_

Enter your name and the name and age of each person that you are picking up prophylaxis for. Use the back of this form for additional persons. Enter weight only for children.

**WARNING: If you are currently taking any other medications, consult with your physician for possible adverse drug interactions.**

Your Home Street Address:

Contact Telephone Number:

City:

State:

Zip Code:

Name: (Last, First)	Age/Weight (Enter weight for children only).	Answer YES or NO for the presence of these symptoms: -Fever -Non-productive cough -Muscle aches -Joint aches <b>-Extreme tiredness</b>	Answer YES or No for the group member who is or is not pregnant or breast feeding.	List any allergies to : -Ciprofloxacin (Cipro) -Tetracycline (Doxycycline) -Penicillin (Amoxicillin) <b>If none, write NO</b>	↓ <b>STAFF USE ONLY</b> ↓	Medication Prescribed	Dose Dispensed	Prophylaxis for ___ days	Lot Number or Label
<i>Example:</i> <i>Doe, John</i>	<i>35 y.</i>	<i>NO</i>	<i>NO</i>	<i>Doxycycline</i>		<i>Cipro</i>	<i>500 mg</i>	<i>10</i>	<i>D1234</i>
1									
2									
3									
4									
5									