



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



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

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

Enter the name and age of each person that you are picking up prophylaxis for. Use others forms for additional persons Enter weight only for children.

**WARNING:** If any person of your group is currently taking any other medications, he/she must consult with his/her physician for possible adverse drug interactions.

**Comments:**

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, breast feeding, or has a child under 6 months of age	List any allergies to : -Ciprofloxacin (Cipro) -Tetracycline (Doxycycline) -Penicillin (Amoxicillin) <b>If none, write NO</b>	STAFF USE ONLY	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>
<b>6</b>									
<b>7</b>									
<b>8</b>									
<b>9</b>									
<b>10</b>									