**Ohio Department of Health**

# One-Page Name, Address, Phone Number and Health History (NAPH)

| Date |
|---|
| Clinic name |

PLEASE PRINT

| **1** Last name | First name | MI | Phone |
|---|---|---|---|
| Home address | | | 2nd phone |
| City | State | ZIP | County |

**2** **Check all that apply**

☐ I am picking up medications for myself. I agree to take them as prescribed.

☐ I am picking up medications for others in my household or people who are unable to pick up their own medications. I am authorized to sign for all of these people, and I agree to provide medications and instructions to all of them. None of these people are receiving additional medications at other mass dispensing clinics.

I understand that the decision to take medication is voluntary. All of the information I have provided to the clinic is true, correct and complete to the best of my knowledge

X
Signature

**3** Enter the names and birthdates of all the people that you are picking up medications for. Put yourself on line 1. Use a second form if you need to.

| **1.** First name | Last name | Date of birth | **2.** First name | Last name | Date of birth | **3.** First name | Last name | Date of birth | **4.** First name | Last name | Date of birth | **5.** First name | Last name | Date of birth |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |

| **4** **Please answer questions 1–5** by checking (✔) Yes or No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Are you taking Accutane, Methotrexate, Lithium, Probenecid, Coumadin, or Digoxin? | | | | | | | | | | |
| 2. Are you taking medication for seizures, tuberculosis (TB), or diabetes? | | | | | | | | | | |
| 3. Are you currently pregnant, breastfeeding, or under 6 months of age? | | | | | | | | | | |
| 4. Are you taking or are you allergic* to any tetracycline antibiotics? Minocin, Periostat, Sumycin,Terramycin, Vibramycin, Vibratab. **Allergic reactions may include: hives, difficulty breathing or wheezing or redness of the skin.* | | | | | | | | | | |
| 5. Do you weigh less than 99 lb? If yes, list weight in pounds. | lbs | | lbs | | lbs | | lbs | | lbs | |

**— STOP —**

## Staff Use Only

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. Taking ropinirole, cyclosporine, glyburide or theophylline? | | | | | | | | | |
| 2. Allergic to quinolones? | | | | | | | | | |
| 3. Kidney problems? (on dialysis or ↓ renal function) | | | | | | | | | |
| **Dispensing doses:** **(Initials of dispenser)** → | | | | | | | | | |
| **Adult** ✔ one: Doxycycline 100 mg BID #20 | | | | | | | | | |
| **Adult** ✔ one: Ciprofloxacin 500 Mg BID #20 | | | | | | | | | |
| **Adult** ✔ one: Other *specify* | | | | | | | | | |
| **0–99 lbs:** Doxycycline | mg / tabs / ml | | | | | | | | |
| **0–99 lbs:** Ciprofloxacin HCL | mg / tabs / ml | | | | | | | | |
| **0–99 lbs:** Other *specify* | mg / tabs / ml | | | | | | | | |
| **Quantity** ☐ 7 days ☐ 10 days ☐ 14 days ☐ 50 days ☐ Other *specify* — Write in lot number or use label — Write in prescription (Rx) # or NDC # or use label | Lot | Rx #/NDC # | Lot | Rx #/NDC # | Lot | Rx #/NDC # | Lot | Rx #/NDC # | Lot | Rx #/NDC # |