Boulder County Public Health (BCPH) Emergency Mass Prophylaxis Screening Form

Contact Information (Person picking up medications today)

First Name:	**Last Name:**	**Phone #:**
Jimmy		

Address: **City:** **State:** CO **Zip Code:**

I agree to read the fact sheets about the disease and emergency medication I am receiving today. I have been provided with contact information for further questions. I understand I can contact the provided resource or my current healthcare provider to ask questions related to the benefits and risks associated with the medications received. The information below is accurate to the best of my knowledge and I consent to accept and distribute the medication for myself and other persons named/listed on this form (front and back). I agree that I am 18 years of age, active guardian, or designee authorized to receive the medications.

Signature of person picking up the medication: _____ **Date:** _____

Fill in the 'YES' circle or the 'NO' circle for each question below.

You and Any Household Members (include last name if different from yours)

	Names	Does person have **Kidney problems**?		Does person weigh **less than 99 lbs**?		**Allergic** to **Cipro** or '**floxacin**'drugs?		Is person **Pregnant**?		**Allergic** to **Doxy** or '**cycline**' drugs?		**Allergic** to **Penicillin** or '**cillin**'drugs?		**DO NOT WRITE BELOW**
		YES	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	
1	Jimmy	◉	○	○	◉	◉	○	○	◉	◉	○	○	◉	A
2	Lisa	○	◉	○	◉	○	◉	○	◉	◉	○	○	◉	C
3	Nick	○	◉	◉	○	○	◉	○	◉	○	◉	○	◉	ANY
4		○	◉	○	◉	○	◉	○	◉	○	◉	○	◉	
5		○	◉	○	◉	○	◉	○	◉	○	◉	○	◉	
6		○	◉	○	◉	○	◉	○	◉	○	◉	○	◉	
7		○	◉	○	◉	○	◉	○	◉	○	◉	○	◉	
8		○	◉	○	◉	○	◉	○	◉	○	◉	○	◉	
9		○	◉	○	◉	○	◉	○	◉	○	◉	○	◉	
10		○	◉	○	◉	○	◉	○	◉	○	◉	○	◉	
Screener:		✔ Give PCP Paper		✔ Give crush paper										

Medication Dispenser:

Medical Screening

Fast Dispensing X