Medical Screening and Consent Form

Please fill out form and answer all questions as much as possible. All information will be kept confidential. Please print clearly.

Name:				Home phone:		
	Last Name	First Name	MI	Cell phone:	Date:	Site:
Address				Work phone:		
	Number and street	City	State	Email:		

PICKING UP MEDICATIONS for	**1**	**2**	**3**	**4**	**5**
	Myself (as above)	**Name**	**Name**	**Name**	**Name**
Sex	☐M ☐ F	☐M ☐ F	☐M ☐ F	☐M ☐ F	☐M ☐ F
Age (list months if less than 1 year old)	___ Years _____ Months	___ Years _____ Months	___ Years _____ Months	___ Years _____ Months	___ Years _____ Months
List antibiotics for which there have been bad allergic reactions including loss of blood pressure, severe rash, or hives					
List weight if less than 100 lbs	**___ lbs.**	**___ lbs.**	**___ lbs.**	**___ lbs.**	**___ lbs.**
Are there any kidney/renal problems?	**Yes☐ No☐**	**Yes☐ No☐**	**Yes☐ No☐**	**Yes☐ No☐**	**Yes☐ No☐**
Is this person pregnant, possibly pregnant? or breastfeeding?	**Yes☐ No☐**	**Yes☐ No☐**	**Yes☐ No☐**	**Yes☐ No☐**	**Yes☐ No☐**
FOR OFFICE USE PLACE RX STICKERS:					

I have read or had explained to me and have received and understand the disease and Drug Information Sheets. I have had my questions answered related to myself and others for whom I am picking up medications. I will share all this information with the people above. I have answered all questions above related to known allergies or health conditions to the best of my ability. I understand the benefits and risks of the prescribed medications. I consent to receive the medications for myself or for the above individual(s) listed on this form. If anyone named above has problems that develop, or if there are questions about taking the medications, a personal physician or the 24-hour hotline will be promptly contacted.

Signature: _____ Date: _____

OFFICE USE ONLY:

Screening/Referral: **Dispensing:** Initials: _____Notes: _____

☐ Dispense / admin. primary antibiotic / vac to all above

☐ Dispense / admin. primary antibiotic / vac to all above, **except:**

_____for patient # _____ _____ for patient #_____ _____ for patient #_____
_____ for patient #_____ _____ for patient #_____