Mississippi State Department of Health Point of Dispensing Health Information Form

Enter the name and age of each person for whom you are picking up medications. **List *your* name first**	Drug allergy to any drug in Tetracycline class (Doxycycline)	Drug allergy to any drug in Quinolone class?	Pregnant or Breastfeeding?	Do you have Myasthenia Gravis?	Do you take Tizanidine/ Zanaflex (a muscle relaxer)?	Do you have epilepsy (seizures) or are you currently taking medication for seizures?	Are you currently taking Warfarin/ Coumadin (a blood thinner)?	Are you on dialysis (kidney machine)?	**Shaded area to be completed by staff (Do not write in shaded area)**
1 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
2_ Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
3 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
4 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
5 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
6 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
7 _Name (Last, First): _____ Age: _____ Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
8 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
9 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
10 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____
11 Name (Last, First): _____ Age:_____Weight if less than 90 pounds: _____	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Doxycycline, Ciprofloxacin, Amoxicillin — Medication Label Here _____

Client Signature: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Primary Phone: _____

❑ I **decline** treatment at this time. The risk and benefit of the use of antibiotics to prevent exposure has been explained to me. _____ *Please initial*

❑ I am picking up medications for myself. I agree to take them as prescribed. _____ *Please initial*

❑ I am picking up medications for others in my household. I am authorized to sign for these people, and I agree to provide the medications and instructions to all of them. _____ *Please initial*

To be completed by POD Staff:

Forms Review Staff: _____ *Please initial* Dispensing Nurse Signature: _____ Date: _____

Examples of medications in the Tetracycline class:

Demeclocyclin (Declomycin)

Doxycycline (Adoxa, Bio-Tab, Doryx, Doxy, Monodox, Periostat, Vibra-Tabs, Vibramycin)

Minocycline (Arestin, Dynacin, Minocin, Vectrin)

Oxytetracycline (Terak, Terra-Cortril, Terramycin, Urobiotic-250)

Tetracycline (Achromycin V, Sumycin, Topicycline, Helidac)

Examples of medications in the Quinolone class:

Acrosoxacin or Rosoxacin (Eradacil)

Cinoxacin (Cinobac)

Ciprofloxacin (Cipro, Ciloxan)

Gatafloxacin (Tequin)

Grepafloxacin (Raxar)

Levofloxacin (Levaquin, Quixin)

Lomefloxacin (Maxaquin)

Moxifloxacin (Avelox, ABC Pak)

Nadifloxacin (Acuatim

Norfloxacin (Chibroxin, Noroxin)

Nalidixic acid (NegGram)

Ofloxacin (Floxin, Ocuflox)

Oxolinic Acid

Pefloxacin (Peflacine)

Rufloxacin

Sparfloxacin (Zagam, Respipac)

Temafloxacin

Trovafloxacin or Alatrofloxacin (Trovan)

Mississippi State Department of Health Point of Dispensing Health Information Form
Form No. 810
Revision 3
05/20/2020

PURPOSE

To collect required health screening information on all clients receiving medication from the Strategic National Stockpile (SNS) in an Open Point of Dispensing or Closed Point of Dispensing facility.

During an All Hazards Event where medical materiel from the Centers for Disease Control and Prevention SNS is required, Points of Dispensing will be opened for medication to be dispensed to the masses. Health information data will be needed for each person who receives medication to determine the correct medication and dosage the client should receive.

INSTRUCTIONS

This form will be completed by each client receiving medication from the SNS for themselves or themselves and their family members. This form is printed on the front and back. The client will complete the front section of the form including: their name, address, and primary telephone number. The client will print the name, age, and weight (if less than 90 lbs.) for themselves and each family member for which they are picking up medication. The client will answer the following eight questions for themselves and each family member for which they are picking up medication: Drug allergy to any drug in Tetracycline class (Doxycycline); Drug allergy to any drug in Quinolone class? *(Examples of medications in the Tetracycline and Quinolone classes are listed on back of form)*; Pregnant or Breastfeeding?; Do you have Myasthenia Gravis?; Do you take Tizanidine/Zanaflex (a muscle relaxer)?; Do you have epilepsy (seizures) or are you currently taking medication for seizures?; Are you currently taking Warfarin/Coumadin (a blood thinner)?; Are you on dialysis (kidney machine)? The client will then choose, check and initial from the following: I **decline** treatment at this time. The risk and benefit of the use of antibiotics to prevent exposure has been explained to me; I am picking up medications for myself. I agree to take them as prescribed; I am picking up medications for others in my household. I am authorized to sign for these people, and I agree to provide the medications and instructions to all of them. Member of Point of Dispensing staff who reviewed the client's form will initial the bottom of page. Point of Dispensing staff dispensing nurse will sign and date bottom of page.

OFFICE MECHANICS AND FILING

The form will be printed and housed in the Office of Emergency Planning and Response. Forms may be requested and obtained from this office. Closed Points of Dispensing will be given a copy of this form at their time of enrollment. At the discretion of the Closed Points of Dispensing facility, they may elect to have their staff complete this form at any

time prior to an actual event. In an actual event where medications are dispensed, these forms will be completed and turned into the Mississippi State Department of Health who will submit to the Centers for Disease Control and Prevention when event is over. A copy may be retained with the Closed Point of Dispensing, if they elect.

RETENTION PERIOD

Copies of the forms will be retained by the Mississippi State Department of Health Office of Emergency Planning and Response Chief Nurse for a period of seven years.