

POD REGISTRATION AND DISPENSING FORM

Please PRINT

INSTRUCTIONS: Please FILL OUT this form completely to receive medicine for you and up to 7 other individuals.

Your Name:	Address:	Phone Number:
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Name (First and Last) [First row, yourself]	Date of Birth (If under 18) [mm/dd/yyyy]	Weight (if under 99 lbs)	Is the person allergic to any of these antibiotics?						Staff Use Only:					
			Doxycycline <i>Vibramycin</i>	Ciprofloxacin <i>Cipro</i>	Amoxicillin Penicillin	Tetracycline <i>Sumycin</i>	Levofloxacin <i>Levaquin</i>	Methicillin Oxacillin	Triage/ Screeener:	Dispenser:	Circle medicine to be given, dose. Initial:	Circle Medicine given, dose. Initial:		
1.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	D 100	C 500	A ___	D 100	C 500	A ___
2.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	D 100	C 500	A ___	D 100	C 500	A ___
3.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	D 100	C 500	A ___	D 100	C 500	A ___
4.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	D 100	C 500	A ___	D 100	C 500	A ___
5.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	D 100	C 500	A ___	D 100	C 500	A ___
6.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	D 100	C 500	A ___	D 100	C 500	A ___
7.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	D 100	C 500	A ___	D 100	C 500	A ___
8.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	D 100	C 500	A ___	D 100	C 500	A ___

POD Location	Comments/notes:
Date/Time	