MEDICATION REGISTRATION FORM

Rev 01.07.13

Page 1: Start on this Side of the Form

TENNESSEE DEPARTMENT OF HEALTH

Enter the name and age of each person for whom you are picking up medications.

**** List your name first ****

Circle below for each person

		Drug Allergy to either Doxycycline or Tetracycline ↓	Under 90 lbs ↓	Pregnant ↓	****** STOP DO NOT WRITE IN SHADED AREA ******	*Shaded Area To Be Completed By Staff*	
1	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
2	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
3	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
4	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
5	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
6	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*

****CONTINUE on back if needed****

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers

Home: ( )

Mobile: ( )

Work: ( )

☐ 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.

Signature_____Date:_____

****WARNING****

The medications you are picking up today may cause side effects, especially if taken with other medications (either prescription or over-the-counter). Talk to your health care provider if you or anyone in your household is taking other medications.

MEDICATION REGISTRATION FORM

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Page 2: Fill Out Other Side of the Form First!

TENNESSEE DEPARTMENT OF HEALTH

Enter the name and age of each person for whom you are picking up medications.		*Circle below for each person*			***Shaded Area To Be Completed By Staff***		
		Drug Allergy to either Doxycycline or Tetracycline ↓	Under 90lbs ↓	Pregnant ↓			
7	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No	****** STOP DO NOT WRITE IN SHADED AREA ******	Doxycycline Ciprofloxacin	*SNS Medication Label Here*
8	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
9	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
10	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
11	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
12	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
13	Name *(Last, First)*: Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
14	Name (Last, First): Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*
15	Name (Last, First): Age: Weight if less than 90 pounds:	Yes No	Yes No	Yes No		Doxycycline Ciprofloxacin	*SNS Medication Label Here*