

# EMERGENCY DISPENSING SITE - REGISTRATION FORM

<b>1</b> Last Name	First Name	MI	Date
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Home Street Address (Not P.O. Box)	City/Town	Zip Code	Phone
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**2 Check all that apply:**

I am picking up medication for myself. I agree to take them as prescribed.

I am picking up medications for others in my household or for people who are unable to pick up their own medications. I am authorized to sign for these people, & I agree to provide medications and instructions to all of them. None of these people will receive medication from other clinics.

*I understand the decision to take medications is voluntary. All the information I provided to the clinic is complete to the best of my knowledge.*

X \_\_\_\_\_  
Signature

**3** Enter the names & birth dates of all people for whom you are picking up medication. Put yourself on line 1. Use a second form if necessary.

	<b>Last Name</b>										
	<b>1.</b>	Date of birth	<b>2.</b>	Date of birth	<b>3.</b>	Date of birth	<b>4.</b>	Date of birth	<b>5.</b>	Date of birth	
<b>4</b>	Does the person weigh less than 99 pounds? If yes, list weight in pounds (lbs). →	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
<b>5</b>	Please circle YES or NO.										
	Is the person taking accutane, digoxin, methotrexate, lithium, probenecid, or coumadin (blood thinner)?	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
	Is the person taking medication for seizures, tuberculosis (TB), or diabetes?	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
	Is the person currently pregnant or breastfeeding?	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
	Is the person taking or allergic* to any tetracycline antibiotics? (Minocin, Periostat, Sumycin, Terramycin, Vibramycin, Vibratab.) *Allergic reactions may include: hives, difficulty breathing or swallowing, wheezing, swelling around the face and throat, or redness of skin.	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO

**BELOW FOR STAFF USE ONLY** **BELOW FOR STAFF USE ONLY** **BELOW FOR STAFF USE ONLY**

<b>A.</b>	Is the person taking ropinirole, cyclosporine, glyburide, or theophylline?	YES	NO								
<b>B.</b>	Is the person allergic to quinolones?	YES	NO								

<b>INITIALS OF DISPENSER</b> →					
Doxycycline	_____ mg				
	tabs ml				
Ciprofloxacin HCL	_____ mg				
	tabs ml				
Other:	_____ mg				
	tabs ml				

EDS bar code sticker (if applicable)	Write in lot number or place bar code sticker from bottle of medication.	Lot # or Sticker				
EDS Name/City/Town						

TURN OVER FOR INSTRUCTIONS

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