

PUBLIC HEALTH NAME, ADDRESS AND PERSONAL HISTORY (NAPH) FORM (*revised 05/2019)



Full Name of Person Picking up Medication

Address

City/State/Zip

Age Phone Email Date

Provide the name and age of each person receiving medication. Answer Yes or No to questions A, B, C, and D for any person for whom you are picking up medication.	A	B	C	D	To Be Completed By Staff
	Is the person allergic to: Doxycycline or Tetracyclines	Is the person allergic to: Ciprofloxacin or Quinolones Or are they taking: Tizanidine (Zanaflex) Or do they have: Myasthenia Gravis	Is the person: Breastfeeding or Pregnant	Does this person weigh less than 76 pounds (lbs) / 34.5 kilograms (kg): If yes, indicate weight	Label
Name <input type="text"/> Age <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs/kg <input type="text"/>	
Name <input type="text"/> Age <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs/kg <input type="text"/>	
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Medical Referral Notes:

Provide the name and age of each person receiving medication. Answer Yes or No to questions A, B, C, and D for any person for whom you are picking up medication.	A	B	C	D	To Be Completed By Staff
	Is the person allergic to: Doxycycline or Tetracyclines	Is the person allergic to: Ciprofloxacin or Quinolones Or are they taking: Tizanidine (Zanaflex) Or do they have: Myasthenia Gravis	Is the person: Breastfeeding or Pregnant	Does this person weigh less than 76 pounds (lbs) / 34.5 kilograms (kg): If yes, indicate weight	Label
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