## PUBLIC HEALTH NAME, ADDRESS AND PERSONAL HISTORY (NAPH) FORM (\*revised 5/2017)

Full Name of Person Picking up Medication							) ()hio	
Address								Department of Health
City/State/Zip								This is an Exercise
Date of Birth		Phone	C	Date				

	A	В	C	D	To Be Completed
Provide the name and age of	Is the person	Is the person	Is the person:	Does this person	By Staff
each person receiving medication.	allergic to:	allergic to:	A Breastfeeding Mother	weigh less than	by stan
	Doxycycline or	Ciprofloxacin or	or Pregnant	76 pounds (lbs):	
Answer Yes or No to questions A, B,	Tetracyclines	Quinolones		If yes, indicate weight	
C, and D for any person for whom		Or are they taking:			1.1.1
you are picking up medication.		Tizanadine (Zanaflex)			Label
		Or do they have:			
		Myasthenia Gravis			
Name				lbs	
Age Gender					
Name				lbs	
Age Gender					
Name				Ibs	
Age Gender					
Name				Ibs	
Age Gender					
Age Gender					
		-			

Medical Referral Notes:

	Α	В	C	D	To Be Completed
Provide the name and age of each person receiving medication.	Is the person allergic to:	ls the person allergic to:	Is the person: A Breastfeeding Mother	Does this person weigh less than	By Staff
each person receiving medication.	Doxycycline or	Ciprofloxacin or	or Pregnant	76 pounds (lbs):	
Answer Yes or No to questions A, B,	Tetracyclines	Quinolones	, , , , , , , , , , , , , , , , , , ,	76 pounds (Ibs): If yes, indicate weight	
C, and D for any person for whom you are picking up medication.		<b>Or are they taking:</b> Tizanadine (Zanaflex)			Label
you are picking up medication.		Or do they have:			
		Myasthenia Gravis			
Name				lbs	
Age Gender					
Nama					
Name				lbs	
Age Gender					
Age Gender					
Name				lbs	
Age Gender					
Name				lbs	
Age Gender					
Name				lbs	
Age Gender					
Name				lbs	
Age Gender			I		

Medical Referral Notes: