

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

Full Name of Person Picking up Medication

Address

City/State/Zip

Date of Birth Phone Date



This is an Exercise

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: Tizanadine (Zanaflex) Or do they have: Myasthenia Gravis	Is the person: A Breastfeeding Mother or Pregnant	Does this person weigh less than 76 pounds (lbs): If yes, indicate weight	Label
Name <input type="text"/> Age <input type="text"/> Gender <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs <input type="text"/>	
Name <input type="text"/> Age <input type="text"/> Gender <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs <input type="text"/>	
Name <input type="text"/> Age <input type="text"/> Gender <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs <input type="text"/>	
Name <input type="text"/> Age <input type="text"/> Gender <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs <input type="text"/>	

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: Tizanadine (Zanaflex) Or do they have: Myasthenia Gravis	Is the person: A Breastfeeding Mother or Pregnant	Does this person weigh less than 76 pounds (lbs): If yes, indicate weight	Label
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Name <input type="text"/> Age <input type="text"/> Gender <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs <input type="text"/>	
Name <input type="text"/> Age <input type="text"/> Gender <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs <input type="text"/>	
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Name <input type="text"/> Age <input type="text"/> Gender <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> lbs <input type="text"/>	

Medical Referral Notes: