

HEAD OF HOUSEHOLD (HOH) FORM

Last Name First Name	Person #1		Person #2		Person #3		Person #4		Person #5		Person #6	
Check box if weight is less than 88 lbs	lbs _____		lbs _____		lbs _____		lbs _____		lbs _____		lbs _____	
Is anyone allergic to medications listed below	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Doxycycline												
Ciprofloxacin												
Amoxicillin												
Is anyone taking any of the medications listed below	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Coumadin												
Dilantin/Seizure Meds												
Theophylline												
*****DO NOT WRITE BELOW THIS LINE*****												
Dispenser Initials/Lot Label	D ___ C ___ A ___		D ___ C ___ A ___		D ___ C ___ A ___		D ___ C ___ A ___		D ___ C ___ A ___		D ___ C ___ A ___	

Your signature serves as consent/authorization to dispense medication for treatment to you and all the members of your household.

**Signature of the person picking up the medication: _____

Date: _____ Address _____ Phone #: _____

The risk and benefit of the use of antibiotics for possible exposure to anthrax has been explained to me. I decline the treatment at this time.

Patient Signature/Date

Witness Signature/Date