

Ohio Department of Health

One-Page Name, Address, Phone Number and Health History (NAPH)

Date
Clinic name

PLEASE PRINT

1 Last name	First name	MI	Phone
Home address			2nd phone
City	State	ZIP	County

2 Check all that apply	3 Enter the names and birthdates of all the people that you are picking up medications for. Put yourself on line 1. Use a second form if you need to.															
<input type="checkbox"/> I am picking up medications for myself. I agree to take them as prescribed.	<table><tr><td>1. First name</td><td>Last name</td><td>Date of birth</td><td>2. First name</td><td>Last name</td><td>Date of birth</td><td>3. First name</td><td>Last name</td><td>Date of birth</td><td>4. First name</td><td>Last name</td><td>Date of birth</td><td>5. First name</td><td>Last name</td><td>Date of birth</td></tr></table>	1. First name	Last name	Date of birth	2. First name	Last name	Date of birth	3. First name	Last name	Date of birth	4. First name	Last name	Date of birth	5. First name	Last name	Date of birth
1. First name		Last name	Date of birth	2. First name	Last name	Date of birth	3. First name	Last name	Date of birth	4. First name	Last name	Date of birth	5. First name	Last name	Date of birth	
<input type="checkbox"/> I am picking up medications for others in my household or people who are unable to pick up their own medications. I am authorized to sign for all of these people, and I agree to provide medications and instructions to all of them. None of these people are receiving additional medications at other mass dispensing clinics.																
I understand that the decision to take medication is voluntary.																
All of the information I have provided to the clinic is true, correct and complete to the best of my knowledge																
X Signature																

4 Please answer questions 1–5 by checking (✓) Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you taking Accutane, Methotrexate, Lithium, Probenecid, Coumadin, or Digoxin?										
2. Are you taking medication for seizures, tuberculosis (TB), or diabetes?										
3. Are you currently pregnant, breastfeeding, or under 6 months of age?										
4. Are you taking or are you allergic* to any tetracycline antibiotics? Minocin, Periostat, Sumycin, Terramycin, Vibramycin, Vibratab. <i>*Allergic reactions may include: hives, difficulty breathing or wheezing or redness of the skin.</i>										
5. Do you weigh less than 99 lb? If yes, list weight in pounds.	lbs		lbs		lbs		lbs		lbs	

— STOP —

Staff Use Only

1. Taking ropinirole, cyclosporine, glyburide or theophylline?										
2. Allergic to quinolones?										
3. Kidney problems? (on dialysis or ↓ renal function)										
Dispensing doses:	(Initials of dispenser) →									
Adult ✓ one	Doxycycline 100 mg BID	#20								
	Ciprofloxacin 500 Mg BID	#20								
	Other <i>specify</i>									
0–99 lbs	Doxycycline	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	
	Ciprofloxacin HCL	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	
	Other <i>specify</i>	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	mg tabs ml	
Quantity	Write in lot number or use label		Write in prescription (Rx) # or NDC # or use label		Lot		Rx #/NDC #		Lot	
<input type="checkbox"/> 7 days										
<input type="checkbox"/> 10 days										
<input type="checkbox"/> 14 days										
<input type="checkbox"/> 50 days										
<input type="checkbox"/> Other <i>specify</i>										