Form #_____

Region 3 Strategic National Stockpile
PATIENT MEDICAL HISTORY and CONSENT FORM

➢ ***Please PRINT the Following Information***

Last Name:_____ **First Name:** _____

Middle Name: _____ **Date of Birth:** ____/____/____ (mm/dd/yyyy) **Age:** _____ **Gender: M** ____ **F** ____

Mother's Maiden Name: _____ **Weight (if under 100 lbs):** _____**lbs.**

Street Address:_____ **City:** _____ **State:** _____ **Zip:** _____

County: _____ **E-mail (*optional*):** _____

Home Phone: (____)_____ **Alternate Phone:** (___)_____

Do you have flu-like symptoms today (fever, aches, chills, cough)? **YES NO (circle one)**
Do you have an open cut/lesion and/or skin-sore? **YES NO (circle one)**
Do you have a known latex allergy? **YES NO (circle one)**

FEMALES ONLY:
Are you currently pregnant or think you might be pregnant? **YES NO (circle one)**
Are you currently breastfeeding? **YES NO (circle one)**

List <u>All</u> Known Allergies:

_____

_____

Do <u>YOU</u> (or the minor you are filling this out for) have any of the following medical conditions? (circle the correct answer for each question) :

YES NO Do you have or had a seizure disorder (such as epilepsy, etc.)?
YES NO Do you take vitamins or supplements (Calcium, Iron, Zinc, Magnesium, Multivitamin, etc.)?
YES NO Do you use antacids (Tums, Maalox, Mylanta, Rolaids, Pepto-Bismol, etc.)?
YES NO Do you have an immunosuppressed medical condition (i.e. HIV/AIDS, Cancer, Lupus, Organ Transplant)
YES NO Taking a Medication Containing Steroids and/or for Cancer Treatment
YES NO Hypersensitivity to Tetracyclines, Quinolones, Penicillins
YES NO Long-term Health Problem Such As: Heart Disease, Kidney Disease, Liver Disease, Diabetes, Lung Disease, Asthma, Anemia, Other (please indicate)_____

List Any Medications You Are Currently Taking:

_____

_____

_____

Additional Medical Information/Concerns:

_____

_____

PARTICIPANT CONSENT OR REFUSAL TO RECEIVE VACCINATION OR MEDICATION

I HAVE: 1) been informed of reasons why I am being vaccinated/receiving medication; **2)** received the vaccine/medication fact sheet indicating the risks and benefits of the vaccine/medication, its side effects, and where I will be able to receive additional information if side effects were to develop; **3)** received information about the infectious agent; **4)** had an opportunity to have my questions answered.

<u>CONSENT</u>: Participant Signature/Parent or Guardian: _____ Date: _____

<u>REFUSAL</u>: Participant Signature/Parent or Guardian: _____ Date: _____

Form #_____

THIS SIDE FOR STAFF USE ONLY

To Be Filled Out For Prophylaxis Medication

Name of Medication:

☐ CIPROFLOXACIN 500mg BID **☐ DOXYCYCLINE 100mg BID** **☐ AMOXICILLIN 500mg TID**
☐ CIPROFLOXACIN _____ **☐ DOXYCYCLINE _____** **☐ AMOXICILLIN _____**

Quantity Dispensed: ☐ 10 Day Supply ☐ 50 Day Supply ☐ 60 Day Supply Other _____

Manufacturer: _____ Lot #: _____

Did the patient receive a medication fact sheet? (Circle one) YES NO

Notes (if applicable): _____

_____

Dispensing Site: _____

Staff Signature: _____ Date: _____

To Be Filled Out For Vaccination

Name of Vaccination (Circle One): ANTHRAX OTHER: _____

Vaccination Site (Circle One): LEFT ARM RIGHT ARM OTHER: _____

Manufacturer: _____ Dose Amount: _____

Vaccine Lot #: _____ Diluent Lot #: _____ Batch #: _____

Notes (if applicable): _____

_____

_____

ASK PATIENT: Have you ever received the anthrax vaccine? YES NO

Did the patient receive the Vaccination Fact Sheet? (Circle one) YES NO

Staff Signature: _____ Date: _____

If Patient Went to Infirmary/Received Counseling

Counseling/Treatment Given By:

Name _____ Title: _____

What was the outcome? Clinician Notes: _____