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

Ohio Department of Health

Full Name of Person Picking up Medication

Address

City/State/Zip

Date of Birth Phone Date

Reset Form Print Form

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 **Is the person allergic to:** Doxycycline or Tetracyclines	B **Is the person allergic to:** Ciprofloxacin or Quinolones **Or are they taking:** Tizanadine (Zanaflex) **Or do they have:** Myasthenia Gravis	C **Is the person:** A Breastfeeding Mother or Pregnant	D **Does this person weigh less than 76 pounds (lbs):** If yes, indicate weight	**To Be Completed By Staff** **Label**
Name Age Gender				lbs	
Name Age Gender				lbs	
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Medical Referral Notes:

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Client Medication List

Date: Prescriber:

Dispensing Location: 24/7 Contact Number:

1.) Name:	
2.) Name:	
3.) Name:	
4.) Name:	
5.) Name:	
6.) Name:	
7.) Name:	
8.) Name:	
9.) Name:	
10.) Name:	