Medication Assessment Form
Missouri Medical Countermeasures/Strategic National Stockpile Program

Name:  
Address:  
City, State, Zip:  
E-Mail:  
Phone:  

Step 1. Place your own name in the first line below. List all household members for whom you are picking up medicine below your name.  

Step 2. For each person listed, answer all 5 questions.  

Step 3. Each person should take the medicine provided exactly as instructed.  

Once you have received your medicine:  
• Be sure to carefully read the fact sheet you have been given.  
• Take the medicine exactly as prescribed unless your medical provider or a public health official tells you to stop. If you stop too soon, you could become sick.  
• Take the medicine even if you feel well. If you do begin to feel sick with symptoms of the disease, it is important to get medical help right away.  
• If you have questions, contact your medical provider or ______________________________________.  

<table>
<thead>
<tr>
<th>Last Name, First Name</th>
<th>Weight if less than 76 pounds?</th>
<th>Yes, No, Don’t Know?</th>
<th>Yes, No, Don’t Know?</th>
<th>Yes, No, Don’t Know?</th>
<th>Yes, No, Don’t Know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxy Tabs</td>
<td>Cipro Tabs</td>
<td>Doxy Tabs Crush Ins</td>
<td>Doxy Susp</td>
<td>Cipro Susp</td>
<td></td>
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Add totals under the columns.

August 2016