

**National Capital
Region Medication
Screening Form**

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**FOR EACH MEMBER OF YOUR HOUSEHOLD,
ANSWER THE FOUR QUESTIONS BELOW WITH
YES, NO OR DON'T KNOW.**

| <p>HOUSEHOLD MEMBERS (Include Yourself)</p> | <p>a. Pregnant or breastfeeding or under 8 years of age</p> | <p>b. Have you been told you are allergic to any of these - doxycycline (Vibramycin) tetracycline (Sumycin) minocycline (Minocin)</p> | <p>c. Have you been told you are allergic to any of these – ciprofloxacin (Cipro) levofloxacin (Levaquin) ofloxacin (Floxin) gatifloxacin (Tequin) moxifloxacin (Avalox)</p> | | |
|--|--|---|--|--|--|
| Household member #1 | | | | | |
| Household member #2 | | | | | |
| Household member #3 | | | | | |
| Household member #4 | | | | | |
| Household member #5 | | | | | |
| Household member #6 | | | | | |
| Household member #7 | | | | | |
| Household member #8 | | | | | |
| Household member #9 | | | | | |
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| <p>Employee:</p> | | | | | |