Audio History Form

Frederick County Fire Fighters

Department:_____ Shift:_____ Job Title:_____
Sex: ____Male ____Female
Type of Test: (Circle one) PREPLACEMENT BASELINE (Initial) ANNUAL
RETEST TERMINATION OTHER
Have you been exposed to noise within the last 14 hours? [ ] Yes [ ] No
Explain:_____
How do you rate your hearing?
[ ] Unknown [ ] Very poor [ ] Average [ ] Good [ ] Very good
Hearing Protection, Do you wear while at work?
[ ] Not used [ ] Seldom Used [ ] Used sometimes
[ ] 1/2 time [ ] Usually used [ ] Always used
If yes, what type of hearing protection do you wear?
[ ] Earplugs [ ] Earmuffs [ ] Both
Brand?_____

MEDICAL HISTORY (Check the correct answer)

10. Ear pain	[ ] Yes [ ] No	25. Scarlet Fever	[ ] Yes [ ] No
11. Draining Ear	[ ] Yes [ ] No	26. Measles	[ ] Yes [ ] No
12. Dizziness/imbalance	[ ] Yes [ ] No	27. Meningitis	[ ] Yes [ ] No
13. Severe ringing	[ ] Yes [ ] No	28. Diabetes	[ ] Yes [ ] No
14. Sudden hearing loss	[ ] Yes [ ] No	29. Kidney disease	[ ] Yes [ ] No
15. Fluctuating hearing loss	[ ] Yes [ ] No	30. Visible wax/object	[ ] Yes [ ] No
		31. Allergies	[ ] Yes [ ] No
16. Fullness/discomfort	[ ] Yes [ ] No	32. Family hearing loss	[ ] Yes [ ] No
17. History of prior disease/ear problem	[ ] Yes [ ] No	33. High noise exposure today	[ ] Yes [ ] No
18. Recent prescription drugs	[ ] Yes [ ] No	34. History of prior ear disease before test	[ ] Yes [ ] No
19. High blood pressure	[ ] Yes [ ] No	35. Head cold today	[ ] Yes [ ] No
20. See MD for ears	[ ] Yes [ ] No	36. Military service	[ ] Yes [ ] No
21. Ear surgery	[ ] Yes [ ] No	37. Noisy hobbies	[ ] Yes [ ] No
22. Unconsciousness	[ ] Yes [ ] No	38. Loud music/ headphones	[ ] Yes [ ] No
23. Wear hearing aid	[ ] Yes [ ] No		
24. Mumps	[ ] Yes [ ] No	39. Firearms/guns	[ ] Yes [ ] No

Explain any 'Yes' responses:
_____
_____

MEDICATIONS (Past & Present) (Please check appropriate boxes.)
[ ] Aspirin, Bufferin, Excedrin (more than 6/day)
[ ] Neomycin [ ] Streptomycin [ ] Gentamycin [ ] Quinine
Explain any checked answers:
_____
_____

_____
Employee Signature Date

OTOSCOPIC EXAM:
Right: [ ] Normal [ ] Abnormal _____Examiners Initials_____
Left: [ ] Normal [ ] Abnormal _____Examiners Initials_____

Comprehensive Medical History

Frederick County Fire Fighters

Allergies: Latex: _____ Yes _____ No
Medication Allergies: _____
Other Allergies:_____

Last Tetanus booster: _____
Current Medications: _____
_____
Current Physician: _____

Medical Illnesses - check all that apply:

___ High Blood Pressure
___ Lung Disease
___ Diabetes
___ Seizures
___ Heart Disease
___ Kidney Disease
___ Anemia
___ Cancer
___ Stomach or Bowel Disorders: _____
___ Sleep Apnea
___ Fractures & Joint Injuries: _____
___ Other: _____
Surgeries: _____

Social History - Check all that apply :

___ Tobacco use
___ Cigarettes: ___ packs/day ___ years
___ Cigars: ___ per day ___ years
___ Pipe: ___ years
___ Chew/Snuff: ___ years

___ Alcohol use ___ Drinks per week

Place an X in the box if you have any of the conditions below now or in the past:
(Caregivers: please comment on positive responses):

Vision (Vision)

__ 1. Do you use glasses?:
__ For reading
__ For distant vision
__ Contacts
__ 2. Are you color blind?

3. Do you have:
__ Retinal disease
__ Cataracts
__ Glaucoma
__ 4. Do you use eye medicine?
__ 5. Have you had eye surgery?
__ 6. Have you had laser exposure?

Heart/Vascular

Do you have:
__16. Chest pain on effort
__17. High blood pressure
__18. Shortness of breath
__19. Swelling of ankles
__20. Heart murmur

Have you had:
__21. Heart attack
__22. Stroke
__23. Rheumatic fever
__24. Heart failure
__25. Heart surgery/Stent/Pacemaker

Hearing
Do you have
__ 7. Difficulty hearing
__ 8. Ear disease
__ 9. Ringing in the ears
__10. Abnormal hearing test
__11. Do you use a hearing aid?
__12. Have you had ear surgery?
__13. Ruptured ear drum?
__14. Exposure to gunfire?
__15. Wear hearing protection?

Liver or Gastrointestinal
Do you have or have you had:

__37. Hepatitis
__38. Cirrhosis
__39. Jaundice
__40. Frequent indigestion
__41. Ulcer disease
__42. Colitis
__43. Other intestinal problems
__44. Do you have a hernia?
__45. Have you had hernia surgery?

Genitourinary:
Do you or have you had:

__46. Kidney trouble
__47. Bladder trouble
__48. Kidney stones

Skin:

__49. Do you have eczema?
__50. Do you have psoriasis?
__51. Any other skin conditions

Neurologic

__52. Tremors
__53. Dizzy spells
__54. Convulsions
__56. Nerve damage
__57. Serious head injury
__58. Brain surgery
__59. Nervous breakdown

Are you taking medication for:

__60. Anxiety or depression
__61. Epilepsy
__62. Parkinson's disease

Respiratory
Do you have:
__26. Chronic cough
__27. Asthma
__28. Bronchitis
__29. Hay fever
__30. Emphysema/COPD
Have you had:
__31. Tuberculosis
__32. Lung cancer
__33. Lung surgery
__34. Silicosis
__35. Asbestos
__36. Black lung

Blood, Endocrine
Have you had:

__63. Anemia
__64. Bleeding problems
__65. Hormone problems
__66. Diabetes
__67. Thyroid problem

Musculoskeletal:
Do you or have you had:

__68. Back trouble
__69. Disc problems/surgery
__70. Shoulder problems/surgery
__71. Arm problems/surgery
__72. Wrist problems/surgery
__73. Hand problems/surgery
__74. Hip problems/surgery
__75. Leg problems/surgery
__76. Knee problems/surgery
__77. Ankle problems/surgery
__78. Foot problems/surgery
__79. Broken bones
__80. Numbness, tingling, and/or pain in hands or arms

Communicable Diseases:
Have you had:

__81. Chicken pox
__82. Measles
__83. German Measles
__84. Mumps
__85. Hepatitis A
__86. Hepatitis B
__87. Hepatitis C

Please list all prior jobs:

Company Name:	Dates Employed:	Job Description:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle any of the following processes and/or jobs done in the past:

Processes: abrasive blasting, acid/alkali treatment, degreasing, electroplating, foundry, forging, painting, welding, grinding or metal machining

Industries: flour,feed or grain, cotton processing, rubber, insulation, quarry work, construction, farming, petroleum, shipyards

Circle any of the following substances to which you have had regular exposure in the workplace:

Fumes or dusts:
silica, coal, asbestos, talc, fiberglass, cotton dust, sawdust, other: _____

Solvents:
benzene, carbon, tetrachloride, trichloroethylene, naptha, xylene, other : _____

Chemicals or gases :
ammonia, formaldehyde, hydrogen sulfide, cyanide, sulfur dioxide, chromium, mercury, lead, cadmium, nickel, other: _____

Miscellaneous:
radiation, insecticides/herbicides, cutting oils, motor exhaust, noise

Have you ever needed medical care for exposure to any of the above?
___ Yes ___ No

Type of problem: Skin: _____ Lungs: _____ Other: _____

Work related injuries and illnesses:

Year:	Injury and treatment:	Time off work:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes	No	Explain if yes
___	___	Have you ever applied for worker's compensation or disability payments for any injury or illness which developed on the job? Explain: _____

___ ___ Are you currently being treated by a doctor for a work related injury or illness? Explain:
_____

_____ _____
Employee Signature Date

_____ _____
Reviewed By Date

f-hxcomp

OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134

Frederick County Fire Fighters

Can you read: [ ] yes [ ] no
Your employer must allow you to answer the questionnaire during normal working hours, or at a time that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A Section 1 (Mandatory). The following information must be provided by every employee who has been selected to use any type of respirator.
Please Print

1. Today's Date: ___/___/_____ 2. Your Name: _____
3. Your Age: _____ 4. Leave Blank _____
5. Your Job Title: _____ 6. Your Date of Birth: ___/___/_____
7. Sex [ ] Male [ ] Female 8. Your Height: ___ feet ___ inches
9. Your Weight: ____ lbs.
10. Phone # where you can be reached to discuss your answers:(___) ____-_____
11. The best time to call you at this number: _____ [ ] a.m. [ ] p.m.
12. Has your employer told you how to contact the health care professional who will review this questionnaire? [ ] yes [ ] no
13. Check the type of respirator you will use. (You can check more than one category)
    [ ] a. N,R, or P disposable respirator (filter-mask, non-cartridge type only).
    [ ] b. Other type (for example, half- or full-facepiece type, powered-air purifying supplied air, self-contained breathing apparatus).
14. Have you worn a respirator? [ ] yes [ ] no
    If yes, what type(s):
    _____
    _____

Part A Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? [ ] yes [ ] no
2. Have you ever had any of the following conditions?
   a. Seizures (fits) [ ] yes [ ] no
   b. Diabetes (sugar disease): [ ] yes [ ] no
   c. Trouble smelling odors: [ ] yes [ ] no
   d. Claustrophobia (fear of closed-in places) [ ] yes [ ] no
   e. Allergic reaction that interfere with your breathing? [ ] yes [ ] no
3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis [ ] yes [ ] no
   b. Asthma [ ] yes [ ] no
   c. Chronic bronchitis [ ] yes [ ] no
   d. Emphysema [ ] yes [ ] no
   e. Pneumonia [ ] yes [ ] no
   f. Tuberculosis [ ] yes [ ] no
   g. Silicosis [ ] yes [ ] no
   h. Pneumothorax (collapsed lung) [ ] yes [ ] no
   i. Lung cancer [ ] yes [ ] no
   j. Broken ribs [ ] yes [ ] no
   k. Any chest injuries or surgeries [ ] yes [ ] no
   l. Any other lung problem you've been told about [ ] yes [ ] no

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: [ ] yes [ ] no
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: [ ] yes [ ] no
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: [ ] yes [ ] no
   d. Have to stop for breath when walking at your own pace on level ground: [ ] yes [ ] no
   e. Shortness of breath when washing or dressing yourself: [ ] yes [ ] no
   f. Shortness of breath that interferes with your job: [ ] yes [ ] no
   g. Coughing that produces phlegm (thick sputum): [ ] yes [ ] no
   h. Coughing that wakes you early in the morning: [ ] yes [ ] no
   i. Coughing that occurs mostly when you are lying down: [ ] yes [ ] no
   j. Coughing up blood in the last month: [ ] yes [ ] no
   k. Wheezing: [ ] yes [ ] no
   l. Wheezing that interferes with your job: [ ] yes [ ] no
   m. Chest pain when you breathe deeply: [ ] yes [ ] no
   n. Any other symptoms that you think may be related to lung problems: [ ] yes [ ] no
5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart attack: [ ] yes [ ] no
   b. Stroke [ ] yes [ ] no
   c. Angina [ ] yes [ ] no
   d. Swelling in your legs and feet (not caused by walking) [ ] yes [ ] no
   e. Heart Failure [ ] yes [ ] no
   f. Heart arrhythmia (irregular heart beat) [ ] yes [ ] no
   g. High blood pressure [ ] yes [ ] no
   h. Any other heart problem that you've been told about: [ ] yes [ ] no
6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in the chest: [ ] yes [ ] no
   b. Pain or tightness in your chest during physical activity: [ ] yes [ ] no
   c. Pain or tightness in your chest that interferes with your job: [ ] yes [ ] no
   d. In the past two years, have you noticed your heart skipping or missing a beat: [ ] yes [ ] no
   e. Heartburn or indigestion that is not related to eating: [ ] yes [ ] no
   f. Any symptoms that you think may be related to heart or circulation problems: [ ] yes [ ] no
7. Do you currently take medication for any of the following problems?
   a. Breathing problems [ ] yes [ ] no
   b. Heart trouble [ ] yes [ ] no
   c. Blood Pressure [ ] yes [ ] no
   d. Seizures (fits) [ ] yes [ ] no
8. If you've used a respirator, have you ever had any of the following problems? (if you've never used a respirator, check the following box and go to question 9. [ ] Never Used
   a. Eye Irritation: [ ] yes [ ] no
   b. Skin allergies or rash [ ] yes [ ] no
   c. Anxiety [ ] yes [ ] no
   d. General weakness or face: [ ] yes [ ] no
   e. Any other problem that interferes with your use of a respirator: [ ] yes [ ] no

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: [ ] yes [ ] no

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever-lost vision in either eye (temporarily or permanently): [ ] yes [ ] no

11. Do you currently have any of the following vision problems:
    a. Wear contact lenses: [ ] yes [ ] no
    b. Wear glasses: [ ] yes [ ] no
    c. Color blind: [ ] yes [ ] no
    d. Any other eye or vision problem: [ ] yes [ ] no

12. Have you ever had an injury to you ears, including a broken eardrum: [ ] yes [ ] no

13. Do you currently have any of the following hearing problems?
    a. Difficulty hearing: [ ] yes [ ] no
    b. Wear a hearing aid: [ ] yes [ ] no
    c. Any other hearing or ear problem: [ ] yes [ ] no

14. Have you ever had a back injury: [ ] yes [ ] no

15. Do you currently have any of the following musculoskeletal problems?
    a. Weakness in any of your arms, hands, legs or feet: [ ] yes [ ] no
    b. Back pain [ ] yes [ ] no
    c. Difficulty fully moving you arms & legs: [ ] yes [ ] no
    d. Pain or stiffness when you lean forward or backward at the waist: [ ] yes [ ] no
    e. Difficulty fully moving your head up or down: [ ] yes [ ] no
    f. Difficulty fully moving your head side to side: [ ] yes [ ] no
    g. Difficulty bending at your knees: [ ] yes [ ] no
    h. Difficulty squatting to the ground: [ ] yes [ ] no
    i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.: [ ] yes [ ] no
    j. Any other muscle or skeletal problem that interferes with using a respirator: [ ] yes [ ] no

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 ft) or in a place that has lower than normal amounts of oxygen: [ ] yes [ ] no

   If 'yes' do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: [ ] yes [ ] no

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: [ ] yes [ ] no

If 'yes' name the chemicals if you know them:

_____

_____

3.Have you ever worked with any of the materials, or under any of the conditions listed below:

a. Asbestos:	[ ] yes	[ ] no
b. Silica:	[ ] yes	[ ] no
c. Tungsten/Cobalt:	[ ] yes	[ ] no
d. Beryllium:	[ ] yes	[ ] no
e. Aluminum:	[ ] yes	[ ] no
f. Coal:	[ ] yes	[ ] no
g. Iron:	[ ] yes	[ ] no
h. Tin:	[ ] yes	[ ] no
i. Dusty environment	[ ] yes	[ ] no
j. Any other hazardous exposures:	[ ] yes	[ ] no

If 'yes' describe the exposure:

4.List any second jobs or side businesses you have:

5.List your previous occupations:

6.List your current & previous hobbies:

7.Have you been in the military service? [ ] yes [ ] no

If 'yes' describe these exposures:

8.Have you ever worked on a HAZMAT team? [ ] yes [ ] no

9.Other than the medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications: [ ] yes [ ] no

If 'yes' name the medications if you know them:

10.Will you be using any of the following items with your respirator(s)?

a. HEPA Filters	[ ] yes	[ ] no
b. Canisters (e.g. gas masks)	[ ] yes	[ ] no
c. Cartridges	[ ] yes	[ ] no

11.How often are you expected to use the respirator:

a. Escape only; no rescue	[ ] yes	[ ] no
b. Emergency rescue only	[ ] yes	[ ] no
c. Less than 5 hours per week	[ ] yes	[ ] no
d. Less than 2 hours per day	[ ] yes	[ ] no
e. 2 to 4 hours per day	[ ] yes	[ ] no
f. Over 4 hours per day	[ ] yes	[ ] no

12. During the period you are using the respirator(s), is your work effort:
    a. Light (less than 200 kcal per hour): [ ] yes [ ] no
       If 'yes', how long does this period last during the average shift
       _____ hours _____minutes
       Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

    b. Moderate (200 to 350 kcal per hour) [ ] yes [ ] no
       If 'yes', how long does this period last during the average shift
       _____ hours _____minutes
       Examples of moderate work effort are sitting while nailing or filing, driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

    c. Heavy (above 350 kcal per hour): [ ] yes [ ] no
       If 'yes', how long does this period last during the average shift
       _____ hours _____minutes
       Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator: [ ] yes [ ] no
    If 'yes' describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77 degrees F) [ ] yes [ ] no
15. Will you be working under humid conditions: [ ] yes [ ] no
16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s)
    Name of toxic substance - #1:
    Estimated maximum exposure level per shift:
    Duration of exposure per shift:

    Name of toxic substance - #2:
    Estimated maximum exposure level per shift:
    Duration of exposure per shift:

Name of toxic substance - #3:
Estimated maximum exposure level per shift:
Duration of exposure per shift:

Name of toxic substance - #4
Estimated maximum exposure level per shift:
Duration of exposure per shift:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well being of others (e.g. rescue, security)

_____ _____
Employee Signature Date

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

_____ _____
PLHCP Signature Date

Respirator Medical Clearance Form

Frederick County Fire Fighters

Please check Type(s) of Respirator(s) to be used:

Air Purifying:
[ ] Negative Pressure (half face or full face)
[ ] PAPR (full face or hood)
[ ] N95 Particulate Respirator

Atmosphere Supplying:
[ ] Airline (continuous flow)
[ ] SCBA (positive pressure, pressure demand)
- open circuit
- closed circuit rebreather)
[ ] Combined (airline/SCBA)

Level of Work Effort: [ ] Light [ ] Moderate [ ] Heavy [ ] Strenuous

Extent of Usage:
[ ] On a daily basis
[ ] Occasionally - but more than once a week
[ ] Rarely - or for emergency situations only

Length of Time of Anticipated Effort in Hours: _____

Special Work Considerations: (i.e. high places, temperature, hazardous material, protective clothing, etc.)

_____

_____

_____ _____
Company Safety Representative Telephone Number

Health Care Provider's Evaluation

_____

Class (check one):
[ ] No restrictions on respirator use
[ ] Some specific use restrictions
[ ] No respirator use permitted
[ ] Need special frames for glasses if required to wear full-face respirator
[ ] No contact lenses

Restrictions:

_____

_____

[ ] FIT TEST TECHNICIAN HAS CONFIRMED THAT FACIAL HAIR IS NOT PRESENT ACROSS RESPIRATOR SEAL AREAS AT THE TIME OF TESTING (OSHA REG 29 CFR 1910.134)

_____ _____
Health Care Provider Signature **Date**

Patient Information

CIPRO (ciprofloxacin)
ORAL TABLET 500mg

Frederick County Health Department: 24-hour
Information Telephone Number: 301-600-1029

This drug treats infections. It belongs to a class of drugs called quinolone antibiotics.

You have been given this drug for protection against possible exposure to an infection-causing bacteria. This drug treats:

 Anthrax

You have been provided a limited supply of medicine. Local emergency health workers or your healthcare provider will inform you if you need more medicine after you finish this supply. If so, upon your follow-up visit, you will be told how to get more medicine. You will also be told if no more medicine is needed.

Take this medicine as prescribed. One tablet by mouth, two times a day.

You will be provided special dosing instructions for children.

Keep taking your medicine, even if you feel okay, unless your doctor tells you to stop. If you stop taking this medicine too soon, you may become infected, or your infection may come back.

You should take this medicine with a full glass of water. Drink several glasses of water each day while you are taking this medicine. It is best to take this medicine 2 hours after a meal. If it upsets your stomach, you may take it with food, but do not take it with milk, yogurt, or cheese. If you miss a dose, take the missed dose as soon as possible. If it is almost time for your next regular dose, wait until then to take your medicine, and skip the missed does. Do not take two doses at the same time.

DRUGS AND FOODS TO AVOID: Do not take the following drugs within 2 hours of taking CIPRO: antacids such as Maalox or Mylanta, vitamins, iron supplements, zinc supplements, or sucralfate (Carafate). You may take them 2 hours after or 6 hours before CIPRO. Also, make sure your doctor knows if you are taking asthma medicine like theophylline, gout medicine like probenecid (Benemid), or a blood thinner such as Coumadin.

Avoid drinking more than one or two caffeinated beverages (coffee, tea, soft drinks) per day. Avoid taking this medicine with foods containing large amounts of calcium, like milk, yogurt or cheese. WARNINGS: If you have epilepsy or kidney disease, or if you are pregnant, become pregnant, or are breastfeeding, tell emergency healthcare workers before you start ciprofloxacin or other quinolone medicines such as norfloxacin (Norosin), ofloxacin (Floxin) or nalidixic acid (NegGram).

This medicine may make you dizzy or lightheaded. Avoid driving or using machinery until you know how it will affect you. This medicine increases the chance of sunburn; make sure to use sunscreen to protect your skin.

SIDE EFFECTS: Call you doctor or seek medical advice right away if you are having any of these side effects: rash or hives; swelling of face, throat, or lips; shortness of breath or trouble breathing; seizures; or severe diarrhea. Less serious side effects include nausea, mild diarrhea, stomach pain, dizziness, and headache. Talk with your doctor if you have problems with these side effects.

Patient Information

DOXYCYCLINE 100MG
ORAL TABLET

Frederick County Health Department: 24-hour Information
Information Telephone Number: 301-600-1029

This drug treats infections. It belongs to a class of drugs called tetracycline antibiotics. You have been given this drug for protection against possible exposure to an infection-causing bacteria.
This drug treats:

 Anthrax

You have been provided a limited supply of medicine. Local emergency health workers or your healthcare provider will inform you if you need more medicine after you finish this supply. If so, upon your follow-up visit, you will be told how to get more medicine. You will also be told if no more medicine is needed.

Take this medicine as prescribed. One tablet by mouth, two times a day.

You will be provided special dosing instructions if you have a child under 8 years of age. Keep taking your medicine, even if you feel okay, unless your healthcare provider tells you to stop. If you stop taking this medicine too soon, you may become infected, or your infection may come back.

You may take your medicine with or without food or milk, but food or milk may help you avoid upset stomach.

If you miss a dose, take the missed dose as soon as possible. If it is almost time for your next regular dose wait until then to take your medicine, and skip the missed dose. Do not take two doses at the same time.

DRUGS AND FOOD TO AVOID: Do not take the following medicines within 2 hours of taking DOXYCYCLINE: antacids such as Maalox or Mylanta, calcium or iron supplements, cholestyramine (Questran) or colestipol (Colestid).

While you are taking this medicine, birth control pills may not work as well; make sure to use another form of birth control.

WARNINGS: If you have liver disease, or if you are or might be pregnant, or if you are breastfeeding, tell emergency healthcare workers before you start taking this medicine.

This medicine increases the chance of sunburn; make sure you use sunscreen to protect your skin. Do not take this medicine if you have had an allergic reaction to any tetracycline antibiotics. Women may have vaginal yeast infections from taking this medicine.

SIDE EFFECTS: Call you doctor or seek medical attention right away if you are having any of these side effects: skin rash, hives, or itching; wheezing or trouble breathing; swelling of the face, lips, or throat. Less serious side effects include diarrhea, upset stomach, nausea, sore mouth or throat, sensitivity to sunlight, or itching of the mouth or vagina lasting more than 2 days. Talk with your doctor if you have problems with these side effects.

Frederick County Health Department, Office of Public Health Preparedness & Response
&
Division of Fire and Rescue Services

Proposition of Antibiotics Program
Medication Screening, Counseling & Consent Form

Print Name:_____ Date of Birth:_____ Sex: Male___ Female___
Last First Day/Mo/Yr

Home Address:_____ Home Phone:_____
Street Address City State Zip Code

Department:_____ Worksite:_____ Work Phone:_____

Please answer the following questions carefully and correctly.

Do you have an questions that have not been answered? Yes No

Are you taking any medication? If yes, list medications.	Yes	No	Comments:
Are you allergic to any medications? If yes, specify.	Yes	No	
Do you have a major medical problem? If yes, specify.	Yes	No	
Have you ever had or have any of the following medical conditions? If yes, please check all that apply: ___Liver Disease ___Kidney Disease ___Skin Disease	Yes	No	
If female: Are you pregnant or planning a pregnancy soon?	Yes	No	
Are you breast-feeding?	Yes	No	
Are you currently using any form of birth control?	Yes	No	

Participant Informed Consent for Prophylaxis medication. I have:
_____received information about the medication.
_____received participant information packet.
_____completed Medication Screening, Counseling and Consent form.
_____had the opportunity to have my questions answered.

I have been informed of why I am being screened for this medication, the risks and benefits associated with the medication, and based on the information provided to me:
_____I have decided to participate in this program
_____I decline to participate in this program.

I have been informed that I will be given this medication by authority of the Frederick County Health Officer when the delay required by normal medication dispensing protocols may pose a greater risk to my health and safety. I agree to take the medication as instructed.

Participant Signature_____ Date_____

FOR HEALTH PROFESSIONAL USE ONLY – Circle appropriate medication(s)

Doxycycline Dose: 100mg BID Ciprofloxacin Dose: 500mg BID

Health Professional Signature: _____ Date_____

Health Professional Name (please print) _____