Emergency Medication Plan-Household Information Form

Chicago Police Department

CPD-11.165 (5/10)

Check box if yes. Record weight if less than 100 lbs.
[Inform CFD personnel if any household member is pregnant at time of incident.]

Member's Name ______ Employee Number ______
Last First M.I.

Department ______ Unit ______

Home Address ______ Zip Code ______ Phone Number ______

D.O.B. ______ Weight ______

- Kidney Disease ☐
- Liver Disease ☐
- Unable to swallow pills ☐
- Immune/Skin disorder (vaccine only) ☐
- Allergic reaction to Ciprofloxacin ☐
- Allergic reaction to Doxycycline ☐
- Allergic to other antibiotics ☐
- Pill pack given ☐
- Liquid pack given ☐
- Vaccine ☐

Household Member

Name ______ D.O.B. ______ Weight ______

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______ Member signature/ Head of Household

______ Date

______ DVC Processor

______ Date