City of Chicago Family Information Form

Check box if yes. Record weight if less than 100 lbs.
Refer to medical oversight desk if any yes responses and/or pregnant.

Member Name _____ Member Number _____

Agency _____ Assignment _____

Home Address _____ Zip Code _____ Phone Number _____

Head of Household _____ Relationship _____

Head of Household _____ Relationship _____

Member

Name _____ Age _____ Weight _____ Pregnant ☐

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

Family Member

Name _____ Age _____ Weight _____ Pregnant ☐

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

Family Member

Name _____ Age _____ Weight _____ Pregnant ☐

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

Family Member

Name _____ Age _____ Weight _____ Pregnant ☐

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Family Member

Name _____ Age _____ Weight _____ Pregnant ☐

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Unable to swallow pills ☐ Allergic to other antibiotics ☐ Vaccine ☐
Immune/Skin disorder (vaccine only) ☐

Member signature/ Head of Household _____ Date _____ DVC Processor _____ Date _____