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 Member			Relationship	
Name		Age	Weight	Pregnant □
Kidney Disease Liver Disease Unable to swallow pill Immune/Skin disorde		Pill Liq	pack given uid pack given ccine	
Family Member		Age	e Weight	Pregnant □
Name L Kidney Disease Liver Disease Unable to swallow pil Immune/Skin disorder	Allergic reaction to Ciprofloxaci Allergic reaction to Doxycycline Is Allergic to other antibiotics	n	pack given uid pack given ccine	
Family Member	,	1 4 4 4 4	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\] Dragnant □
Name		Age		☐ Pregnant ☐
Kidney Disease Liver Disease	Allergic reaction to Ciprofloxaci		pack given Uid pack given]
Unable to swallow pill	Allergic reaction to Doxycycline Allergic to other antibiotics		ccine]
Immune/Skin disorder	(vaccine only)			-
Family Member		Age	Weight	Pregnant \square
Name Lidney Disease Liver Disease Unable to swallow pillomune/Skin disorder			pack given	
Family Member				
Name		Age	e Weight	Pregnant
Kidney Disease Liver Disease Unable to swallow pill Immune/Skin disorder		☐ Liqu	pack given	
Member signature/ Head of	Household Date		DVC Processor	Date