

ANTIVIRAL MEDICATION RECORD FORM

**YORK CITY BUREAU OF HEALTH – ALBERT S. WEYER HEALTH CENTER
435 W. PHILADELPHIA ST., YORK, PA 17401
TELEPHONE: 849-2299.....FAX: 843-5605**

1. PATIENT INFORMATION (to be completed by Medical Provider)

Name _____
(First, Middle and Last)
Age _____ DOB _____ Sex: Male _____ Female _____
Address _____
City _____ State _____ Zip _____
Telephone # _____

2. MEDICAL PROVIDER CERTIFICATION (to be completed by Medical Provider)

I certify that I have evaluated this patient and find that he/she has influenza or an influenza-like illness that would most likely benefit from anti-viral medication and that my patient is unable to afford to pay for a prescription of this medication or unable to obtain this medication at a pharmacy.

Name of Antiviral to be dispensed by Health Bureau _____
Dose/Frequency/Duration _____

Medical Provider's Name (Print) _____

Signature _____ Date _____

3. DRUG INFORMATION (to be completed by Health Bureau only)

Drug Name: <u>Tamiflu (Oseltamivir phosphate)</u>	Drug Name: <u>Relenza (Zanimivir)</u>
Lot Number _____	Lot Number _____
Expiration Date _____	Expiration Date _____
Dosage Form: <input type="checkbox"/> 30 mgs capsules	Dosage Form: 5 mgs/blister (for inhalation only)
<input type="checkbox"/> 45 mgs capsules	
<input type="checkbox"/> 75 mgs capsules	
<input type="checkbox"/> Oral Suspension (12 mg/ml)	
SNS/PADOH Supply _____ YCBH Supply _____	

4. ADMINISTRATOR INFORMATION (to be completed by Health Bureau only)

Name of Drug Administrator _____

Signature _____ Date _____

5. RECIPIENT INFORMATION (to be completed at time of delivery)

Name of Recipient (Print) _____

Signature _____ Date _____