

Nursing Assessment				<b>ERYTHROMYCIN</b> Those ≥ 1 Month of Age							
NAME: SURNAME	GIVEN NAMES	i	1	PHN		AGE	DATE OF BIRTH YYYY	MM	DD		
ADDRESS					WEIGHT	KG	PHONE NUMBE	R	1		
ALLERGIES TO: Erythromycin: Contraindication to Erythromycin:	U YES		PUBLIC F	HEALTH NURSE SI	GNATURE		DATE SIGNED YYYY	ММ	DD		

#### To the Dispensing Pharmacist

ERYTHROMYCIN (≥ 1 MONTH OF AGE):	OR	base
Erythromycin 40 mg/kg/day (max. 1 gm/day) =		mg/day po divided in 3 doses x 7 days

#### Medical Health Officer Signature

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HLTH 2377 REV. 2006/01/25



## **PRESCRIPTION FOR CHEMOPROPHYLAXIS** Following Exposure to Pertussis Disease

**ERYTHROMYCIN** Those  $\geq$  1 Month of Age

Nursing	Assessment	

Nursing Assessment									
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NAME: SURNAME	GIVEN NAMES			PHN		AGE	DATE OF BIRTH		
							YYYY	MM	DD
ADDRESS					WEIGHT		PHONE NUMBE	R	
						KG			
ALLERGIES TO:			PUBLIC	HEALTH NURSE SIG	GNATURE		DATE SIGNED		
							YYYY	MM	DD
Erythromycin:	YES	NO							
Contraindication to Erythromycin:	YES								
	L TES	NO NO							

#### To the Dispensing Pharmacist

ERYTHROMYCIN (≥ 1 MONTH OF AGE):	OR	base
Erythromycin 40 mg/kg/day (max. 1 gm/day) =		mg/day po divided in 3 doses x 7 days

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#### **AZITHROMYCIN** ADNITHS OF AGE INCLUSIVE INFANTS DID

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NAME: SURNAME	GIVEN NAME	ŝ	PHN			AGE	DATE OF BIRTH YYYY	ММ
ADDRESS					WEIGHT	KG	PHONE NUMBE	R
ALLERGIES TO:			PUBLIC HEAL	TH NURSE SIG	GNATURE		DATE SIGNED	
Azithromycin:	YES	NO					YYYY	MM
Contraindication to Azithromycin:	YES	NO						

## To the Dispensing Pharmacist

AZITHROMYCIN (INFANTS BIRTH TO 5 MONTHS OF AGE INCLUSIVE):

10 mg / kg per day in a single dose for 5 days

## **Medical Health Officer Signature**

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HLTH 2378 A REV. 2006/02/06



## **PRESCRIPTION FOR CHEMOPROPHYLAXIS** Following Exposure to Pertussis Disease

**AZITHROMYCIN** INFANTS BIRTH TO 5 MONTHS OF AGE INCLUSIVE

Nursing Assessment

Nursing Assessment								
NAME: SURNAME	GIVEN NAMES		PHN		AGE	DATE OF BIRTH YYYY	ММ	DD
ADDRESS				WEIGHT	KG	PHONE NUMBE	3	
ALLERGIES TO: Azithromycin: Contraindication to Azithromycin:	YES	PUBLIC	HEALTH NURSE SI	GNATURE		DATE SIGNED YYYY	ММ	DD

## To the Dispensing Pharmacist

AZITHROMYCIN (INFANTS BIRTH TO 5 MONTHS OF AGE INCLUSIVE):
10 mg / kg per day in a single dose for 5 days

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Nursing Assessment							OMYCIN INTHS OF AG	E	
NAME: SURNAME	GIVEN NAMES	F	PHN			AGE	DATE OF BIRTH YYYY	мм	DD
ADDRESS		·			WEIGHT	KG	PHONE NUMBE	R	1
ALLERGIES TO:		PUBLIC H	HEAL	TH NURSE SIG	GNATURE		DATE SIGNED		
Azithromycin: Contraindication to Azithromycin:	YES						YYYY	MM	DD

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#### To the Dispensing Pharmacist

AZITHROMYCIN (≥ 6 MONTHS OF AGE):	
10 mg / kg per day (max. 500 mg) once for one day =	mg for one day, then
5 mg / kg per day (max. 250 mg) =	mg/day once a day for 4 days

# Medical Health Officer Signature

TH 2378 B REV. 2006/02/06



## **PRESCRIPTION FOR CHEMOPROPHYLAXIS** Following Exposure to Pertussis Disease

Nursing Assessment							OMYCIN ONTHS OF AG	E	
NAME: SURNAME	GIVEN NAMES		PHN	l		AGE	DATE OF BIRTH YYYY	MM	DD
ADDRESS					WEIGHT	KG	PHONE NUMBE	R	
ALLERGIES TO: Azithromycin: Contraindication to Azithromycin:	YES	□ NO □ NO	PUBLIC HEA	LTH NURSE SI	GNATURE		DATE SIGNED	ММ	DD

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## To the Dispensing Pharmacist

AZITHROMYCIN (≥ 6 MONTHS OF AGE):	
10 mg / kg per day (max. 500 mg) once for one day =	mg for one day, then
5 mg / kg per day (max. 250 mg) =	mg/day once a day for 4 days

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Nursing Assessment						COMYCIN		
NAME: SURNAME	GIVEN NAMES	Pł	HN		AGE	DATE OF BIRTH YYYY	MM	DD
ADDRESS				WEIGHT	KG	PHONE NUMBE	R	
ALLERGIES TO:		PUBLIC HE	EALTH NURSE SIG	GNATURE		DATE SIGNED		
Clarithromycin: Contraindication to Clarithromycin:	YES					YYYY	MM	DD

#### To the Dispensing Pharmacist

CLARITHROMYCIN (≥ 1 MONTH OF AGE):	
15 mg/kg/day (max. 1 gm/day) =	_ mg/day po divided in 2 doses x 7 days

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## **PRESCRIPTION FOR CHEMOPROPHYLAXIS** Following Exposure to Pertussis Disease

BC Centre for Disease Control Nursing Assessment	CLARITHROMYC THOSE > 1 MONTH OF								
NAME: SURNAME	GIVEN NAMES		F	Ϋ́ΗΝ		AGE	DATE OF BIRTH YYYY	MM	DD
ADDRESS					WEIGHT	KG	PHONE NUMBE	R	<u> </u>
ALLERGIES TO: Clarithromycin:	YES	NO	PUBLIC H	EALTH NURSE SIG	GNATURE		DATE SIGNED YYYY	MM	DD
Contraindication to Clarithromycin:	YES	NO							

#### To the Dispensing Pharmacist

CLARITHROMYCIN (≥ 1 MONTH OF AGE):	
15 mg/kg/day (max. 1 gm/day) =	_ mg/day po divided in 2 doses x 7 days

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**TRIMETHOPRIM - SULPHAMETHOXAZOLE** FROM TWO MONTHS TO  $\leq 12$  years of Age

#### **Nursing Assessment**

NAME: SURNAME	GIVEN NAMES			PHN		AGE	DATE OF BIRTH YYYY	MM	DD
ADDRESS					WEIGHT		PHONE NUMBE	R	
						KG			
ALLERGIES TO:			PUBLIC	HEALTH NURSE SIG	GNATURE		DATE SIGNED		
Trimethoprim - Sulphamethoxazole:	YES	NO					YYYY	MM	DD
Contraindication to Trimethoprim - Sulphamethoxazole:	YES	NO							

#### To the Dispensing Pharmacist

TRIMETHOPRIM - SULPHAMETHOXAZOLE:	
Liquid suspension Tablet	
Child two months to $\leq$ 12 years -Trimethoprim 4mg/kg = mg and Sulphamethoxazole 20mg/kg = mg p.o. b.i.d. x 14 days.	
(To a maximum of the adult dose)	

#### Medical Health Officer Signature

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HLTH 2380 REV. 2006/02/06



## **PRESCRIPTION FOR CHEMOPROPHYLAXIS** Following Exposure to Pertussis Disease

**TRIMETHOPRIM - SULPHAMETHOXAZOLE** From Two Months to  $\leq 12$  years of Age

#### Nursing Assessment

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NAME: SURNAME	GIVEN NAMES			PHN		AGE	DATE OF BIRTH		
							YYYY	MM	DD
ADDRESS					WEIGHT		PHONE NUMBE	R	
						KG			
						Nu			
ALLERGIES TO:			PUBLIC	HEALTH NURSE SIG	GNATURE		DATE SIGNED		
	_						2000/		
Trimethoprim - Sulphamethoxazole:	YES	NO					YYYY	MM	DD
Contraindication to									
Trimethoprim - Sulphamethoxazole:	YES	□ NO							

## To the Dispensing Pharmacist

TRIMETHOPRIM - SULPHAMETHOXAZOLE:	
Liquid suspension Tablet	
Child two months to ≤ 12 years -Trimethoprim 4mg/kg = mg and Sulphamethoxazole 20mg/kg = mg p.o. b.i.d. x 14 days.	
(To a maximum of the adult dose)	

#### Medical Health Officer Signature

MSC #



#### TRIMETHOPRIM - SULPHAMETHOXAZOLE Adult or Child over 12 years

#### **Nursing Assessment**

NAME: SURNAME	GIVEN NAMES			PHN	AGE	DATE OF BIRTH YYYY	MM	DD
ADDRESS				1	1	PHONE NUMBE	R	1
ALLERGIES TO: Trimethoprim - Sulphamethoxazole:	YES	NO	PUBLIC	HEALTH NURSE SIGNATURE		DATE SIGNED YYYY	MM	DD
Contraindication to Trimethoprim - Sulphamethoxazole:	YES	NO						

#### To the Dispensing Pharmacist

TRIMETHOPRIM - SULPHAMETHOXAZOLE:
ADULT or CHILD over 12 years - Trimethoprim 160mg and Sulphamethoxazole 800mg b.i.d. x 14 days.

#### Medical Health Officer Signature

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HLTH 2381 REV. 2006/02/06



#### **PRESCRIPTION FOR CHEMOPROPHYLAXIS** Following Exposure to Pertussis Disease

#### **TRIMETHOPRIM - SULPHAMETHOXAZOLE** Adult or Child over 12 years

#### **Nursing Assessment**

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NAME: SURNAME	GIVEN NAMES			PHN	AGE	DATE OF BIRTH YYYY	MM	DD
ADDRESS						PHONE NUMBE	R	
ALLERGIES TO: Trimethoprim - Sulphamethoxazole:	YES	NO	PUBLIC	HEALTH NURSE SIGNATURE		DATE SIGNED YYYY	MM	DD
Contraindication to Trimethoprim - Sulphamethoxazole:	YES	NO						

#### To the Dispensing Pharmacist

TRIMETHOPRIM - SULPHAMETHOXAZOLE:	
ADULT or CHILD over 12 years - Trimethoprim 160mg and Sulphamethoxazole 800mg b.i.d. x 14 days.	

#### Medical Health Officer Signature

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