



**POTASSIUM IODIDE (KI) DISTRIBUTION FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: PA Zip: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Phone (Work): \_\_\_\_\_

Number of Household Members: \_\_\_\_\_

\_\_\_\_\_  
Signature of Family Member Receiving KI Date

Note: You will be contacted when your order is ready for pickup at the Pottstown Health Center.

\_\_\_\_\_  
\_\_\_\_\_  
(To be completed by Health Department Staff)

KI Fact Sheet in envelope (check box)

Number of Potassium Iodide tablets given: \_\_\_\_\_

\_\_\_\_\_  
Signature of staff member Date