



UMFS Report of Medical Visit

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Reason for medical visit:

Prognosis:

Changes to Meds (Name)	Dosage	Time Given	Purpose	Action Taken (increase, decrease, added, discontinued)

**Drug interactions with any current or over the counter medications and side effects of new medications were discussed with the Resource Family and/or client**

Doctor's Name (Print): \_\_\_\_\_

M.D. Signature: \_\_\_\_\_

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

Address and Phone number of Physician:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Revised 12/18/2012

**Note: Permission needs to be obtained from the legal guardian for new medications or changes in medications.**

Written Permission:

Parent/Guardian \_\_\_\_\_

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

Verbal Permission Obtained From:

Name \_\_\_\_\_

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

Verbal Permission Obtained By: Name:

\_\_\_\_\_

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