UMFS

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: _____