MEDICAL INFORMATION

Medical History and/or Medical Concerns:

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Current Medications:

1. ______________________ **Dosage:** ____________ **Prescribed by:** ____________________

2. ______________________ **Dosage:** ____________ **Prescribed by:** ____________________

3______________________ **Dosage:** ____________ **Prescribed by:** ____________________

Current Physicians:

1. Name: ____

Specialty: ____

Phone: ____

Treatment: ____

Duration of Treatment: ____

2. Name: ____

Specialty: ____

Phone: ____

Treatment: ____

Duration of Treatment: ____

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MEDICAL INFORMATION (CONTINUED)

Current Therapies (e.g. Mental Health, Speech and Language, Occupational):

1. Name: ______________________________

Specialty: ______________________________

Phone: ______________________________

Treatment: ______________________________

Duration of Treatment: ______________________________

2. Name: ______________________________

Specialty: ______________________________

Phone: ______________________________

Treatment: ______________________________

Duration of Treatment: ______________________________

Hospitalization History:

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Trauma History:

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Other Traumatic Events (e.g. death of loved one, injury, accident, divorce, loss of close teacher, communication difficulties, surgeries, family moves, school changes, etc.):

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