PROVO SCHOOL DISTRICT
Medical History Care Form

MEDICAL OVERVIEW

School: ______________________________ Teacher: ______________ Grade: ____
Student Name: _________________________________ Birth Date: ______________
Parents Name: ____
Home Address: ____
Home/Work/Cell Phone: ____
Emergency Contact: ____

PHYSICIAN (S)

Primary Physician (s): ____
Phone/Fax: ____
Specialty Physician (s): ____
Phone/Fax: ____
Medical Insurance: ____________________________ Group#: _________________

MEDICAL HISTORY

Brief Medical History**:** ____
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____

Medical & Diagnosis Condition: ____
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Allergies: ____
Diet: ____
Equipment: ____
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MEDICATIONS

Medication: ______________________________ Dosage: ______ Time: _____
Medication: ______________________________ Dosage: ______ Time: _____
Medication: ______________________________ Dosage: ______ Time: _____
Medication: ______________________________ Dosage: ______ Time: _____
Medication: ______________________________ Dosage: ______ Time: _____

TRANSPORTATION

Transportation: ____

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Procedures: ____

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Standing Orders for Emergency: ______________________________________

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Parent Signature: ___________________________________ Date: __________
Physician Signature: ________________________________ Date: __________