The Crowden School
1475 Rose Street ~ Berkeley, CA 94702 ~ 510.559.6910 ~ 510.559.6940 FAX

*For school use only: Verified by*_____
*Date*_____
*Form D required**: Yes □ No □*

2019-2020 STUDENT MEDICAL AND EMERGENCY INFORMATION

Student: _____

Parent(s)/Guardian(s) 1: _____

_____

Home phone:_____ Work phone: _____Cell phone: _____

Parent(s)/Guardian(s) 2: _____

_____

Home phone:_____ Work phone: _____Cell phone: _____

I. MEDICAL INSURANCE INFORMATION

The Crowden School does not carry medical insurance for students and requires that students carry their own.

Medical insurance carrier: _____

Policy number: _____

Physician's or pediatrician's name: _____

Name of Medical Practice or Group: _____

Address: _____

_____

Phone: _____

II. EMERGENCY CONTACT INFORMATION (Other than parent)

Please provide the name of a relative, neighbor, or friend who (if possible) lives near TCS in the event that parent(s) or guardian(s) cannot be reached.

1. Name:_____Relationship: _____

Address: _____

_____

Home:_____Work:_____ Cell: _____

2. Name:_____Relationship: _____

Address: _____

_____

Home:_____Work:_____ Cell: _____

3. Out of state contact

Name:_____Relationship: _____

Address: _____

_____

Home:_____Work:_____ Cell: _____

Attachment C: *for families to complete*

The Crowden School
1475 Rose Street ~ Berkeley, CA 94702 ~ 510.559.6910 ~ 510.559.6940 FAX

III. ADMINISTRATION OF TYLENOL/ADVIL: For general discomfort at school we can administer Tylenol or Advil, with your permission. You will be notified if your child receives any medication at school. Please indicate if you do **not** want your child to be given either medication:

❑ **No,** my child may not be given: ❑ Tylenol **and / or** ❑ Advil

❑ **Yes,** my child may be given either Tylenol or Advil

❑ **Wait,** I'd prefer to be contacted BEFORE my student receives any medication

_____

Parent signature

IV. AUTHORIZATION OF CONSENT TO TREATMENT OF MINOR

1. I/we, the undersigned parent(s) and/or guardian(s) of _____ , a minor, do hearby authorize The Crowden School as agent for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care that is deemed advisable by, and is to be rendered under the general and special supervision of any physician and surgeon licensed under the provisions of The Medicine Practice Act on the Medical Staff of any licensed hospital, whether such diagnosis or treatment is rendered at the office of _____.

2. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment, or hospital care that the aforementioned physician in the exercise of his or her best judgement may deem advisable.

_____ _____

Parent/guardian signature *date*

_____ _____

Parent/guardian signature *date*

V: DATE OF LAST TETANUS SHOT? _____

VI. DENTAL INSURANCE INFORMATION

The Crowden School does not carry dental insurance for students and requires that students carry their own.

Dental insurance plan: _____

Dentist's Name: _____

Address: _____

_____

Phone: _____

Attachment C: *for families to complete*

The Crowden School
1475 Rose Street ~ Berkeley, CA 94702 ~ 510.559.6910 ~ 510.559.6940 FAX

VII. MEDICAL SURVEY: **If items are listed in this section, Form D, Medical History Questionnaire, is required to be completed by your child's physician.

List food allergies of any kind and specify the nature of your child's reaction (contact, airborne, ingestion):

_____

Other allergies (medicine, pollen, etc.):

_____

Please list any other medical problems or chronic conditions (asthma, etc.):

_____

_____

Medicines taken regularly (including over-the-counter medicines):*

Reasons taken: _____ Dose/Frequency: _____

***All medications must be kept in the main office. Students are not allowed to carry or store medication on campus at any time, with the exceptions of inhalers and EpiPens that are required for the treatment of allergy symptoms.**

VIII. YEARLY MEDICAL HISTORY UPDATE

Medical conditions and allergies (check, giving approximate dates):

- ❑ Convulsions
- ❑ Diabetes
- ❑ Heart Defect/Disease
- ❑ Hypertensions
- ❑ Psychiatric Treatment
- ❑ Chicken pox
- ❑ German Measles
- ❑ Mumps
- ❑ Hepatitis
- ❑ Bleeding/clotting
- ❑ Asthma
- ❑ Hay Fever
- ❑ Penicillin
- ❑ Other drugs: _____

Operations and/or serious injuries (please include dates):

_____

_____

Have you ever consulted with a specialist of any sort about your child?

_____

_____

Has your child been evaluated for emotional or learning differences?

_____

_____

Has your child ever received any psychiatric treatment?

_____

_____

Attachment C: *for families to complete*