



The Crowden School

1475 Rose Street ☞ Berkeley, CA 94702 ☞ 510.559.6910 ☞ 510.559.6940 FAX

2020-2021 MEDICAL HISTORY QUESTIONNAIRE HEALTH EXAMINATION BY LICENSED PHYSICIAN

Must be submitted if Section VII on Attachment C has entries and by all new students

Student Name: _____ Physician Name: _____

I have examined the above student within the past two years, on (date): _____

In my opinion, this student's condition **does** / **does not** preclude his/her participation in a full physical education program and team sports.

This student is under the care of a physician for the following condition(s):

Allergies (food, medication, other) _____

****Medical Treatment for exposure to allergen. Please note that any student medications must be in the original container and include the label with dosage and usage instructions. A written medical treatment plan must be submitted for all allergies and any serious medical conditions.**

Explanation of any reported loss of consciousness, convulsion, or serious head injury:

Any restrictions on school activities? _____

Additional health information: _____

Would it be helpful to discuss this student's medical condition? **Yes** **No**

If so, may we telephone you? **Yes** **No**

PHYSICIAN INFORMATION

Physician's signature: _____ Date: _____

Address: _____ Telephone: _____

Attachment D: for Physician's use