School office use only. Verified by________________
Date________________________
Asthma ☐ Allergy ☐ Other ☐

The Crowden School

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

2019-2020 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*