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

2023-2024 Medical History Questionnaire

HEALTH EXAMINATION BY LICENSED PHYSICIAN

Must be submitted by all new students OR if Section VIII on Attachment D has entries.

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 their 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: _____

_____

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

_____

_____

_____

_____

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 C: *for Physician's use*