Garcia Street Club

Physician Form

Child's Name: _____ D.O.B._____

This section to be completed by PHYSICIAN:

I have known this child since: _____ Date of last exam: _____

Please circle any present health concern(s):

bee sting allergy

allergies

asthma

diabetes

congenital anomalies

emotional problems

urinary difficulties

hearing difficulties

visual difficulties

abnormal bleeding

scoliosis

seizures

cardiac difficulties

other(s):

_____

_____

_____

_____

Please Note: **All life threatening health conditions, allergies and asthma conditions require a health care plan prior to attending school.**

Please list ANY current medication(s)and dosages:_____

_____

I have examined this child and find him/her physically able to participate in:

____ all physical activity ____ limited physical activity ____ no physical activity

Please explain nature and duration of any limitation(s): _____

_____

Physician signature: _____ Date: _____

Additional Comments: _____

_____

_____

_____

_____

_____