Pomeroy Recreation and Rehabilitation Center
Children and Teens Department
207 Skyline Boulevard San Francisco, California 94132
main: (415) 665-4100 fax: (415) 665-7543

PHYSICIAN'S MEDICAL FORM

MEDICAL RELEASE – Parents/Guardians fill out and sign the release FIRST, then give to your child's physician to complete the rest.

I hereby give my full permission to Dr. _____ to provide the medical information requested below to the Pomeroy Recreation & Rehabilitation Center (PRRC). I understand that this information is confidential and will become part of my child's permanent record at PRRC

Child's Name _____ Parent/Guardians Signature _____
Date: _____ / _____ / _____

Both sides must be filled out completely and signed by your child's doctor

PERSONAL INFORMATION

Name _____ DOB _____

Diagnosis _____ Onset _____

Prognosis _____

MEDICATION INFORMATION

Medication _____ Dosage _____ Time Given _____

Significant Side Effects _____

_____

Medication _____ Dosage _____ Time Given _____

Significant Side Effects _____

_____

Medication _____ Dosage _____ Time Given _____

Significant Side Effects _____

_____

Yes ____ No ____ Can we give over-the-counter medications (such as Aspirin, Ibuprofen, Tylenol, Pepto-Bismol, Neosporin…etc) as needed with the parents' permission to the child. **If "no"**, please explain.

_____

_____

_____

ILLNESS/IMMUNIZATION RECORD (please attach a copy of child's immunization records)

Chicken Pox	Yes ____	No ____	Date _____	Rheumatic Fever	Yes ____	No ____	Date _____
Mumps	Yes ____	No ____	Date _____	Whooping Cough	Yes ____	No ____	Date _____
Measles	Yes ____	No ____	Date _____	Rubella	Yes ____	No ____	Date _____
Hepatitis B	Yes ____	No ____	Date _____	HIB Meningitis	Yes ____	No ____	Date _____
Poliomyelitis	Yes ____	No ____	Date _____	DPT	Yes ____	No ____	Date _____ _

OVER...OVER...OVER...OVER.

SCREENING OF TB: _____

TB Test Date: _____/_____/_____ ☐ Positive ☐ Negative

If Positive, date of Chest X-Ray: _____/_____/_____ Results: _____

OTHER HEALTH RELATED CONDITIONS

Seizures/Epilepsy Yes ____ No ____ Heart Problems Yes ____ No ____ Hearing/Ear Problem Yes ____ No ____
Incontinence Yes ____ No ____ Skin Problems Yes ____ No ____ Asthma/Resp. Problems Yes ____ No ____
Diabetes Yes ____ No ____ Open Sores/Lesions Yes ____ No ____ High Blood Pressure Yes ____ No ____
Vision/Corrective Lenses Yes ____ No ____ Other _____

If "Yes", to any please explain _____

_____

PATIENT HISTORY

Yes ___ No ___ Does patient have allergies or diet restrictions? **If "yes",** please explain

_____

_____

Yes ___ No ___ Does patient require any special assistance or device for walking? **If "yes"**, please specify.

_____

_____

Yes ___ No ___ Can patient exit a building independently during an emergency?

Yes ___ No ___ Is patient receiving therapy or being seen by other doctors? **If "yes",** please list.

Name Titles

_____

_____

_____

Yes ___ No ___ Do you believe this child or teen requires the special attention of adults in a childcare/ after-school program setting?

Yes ___ No ___ Does patient have emotional/behavioral problems? **If "yes",** please describe.

_____

_____

_____

Yes ___ No ___ Are there any physical limitations or activities that should be avoided? **If "yes",** please explain.

_____

_____

Date of Last Physical _____/_____/_____

DOCTOR'S INFORMATION

Doctor's Name _____ Phone Number: (_____)_____

Address _____ City _____ Zip Code _____

Doctor's Signature **(REQUIRED)** _____ **Today's Date** _____/____/_____