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Golden Gate Pediatrics

To ensure our doctors have the most up-to-date information, please complete the following form.

Before submitting your form to our office, please make sure all portions of your form that are not to be completed by your doctor are complete.

Patient's Name: _____ DOB: _____

Primary Care Physician: _____

Method to return form: (pick one) **1**) upload to portal, **2**) call for pick-up, **3**) fax, or **4**) mail

Phone #, Fax # or Address: (if applicable) _____

Pick one: **1.)** Standard Processing \$15 (5-7 business days) **2.)** Rush Processing \$25 (1 business day)

1) Are there any medications that are going to be taken at camp/school? Yes
No

(If yes, please list medications taken, dosage and how often the medication is taken.)

2.) Does your child have any allergies? Yes
No

(If yes, please specify.)

- insects _____
- food _____
- medication _____
- other _____

3.) Does your child require use of an Epi-Pen? Yes
No

4.) Is there anything else the camp/school should or should not know?
(ex. asthma, diabetes, seizures)

Tuberculosis Screening Questionnaire

5.) Was your child born in a high-risk country (Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East)? Yes No

6.) Has your child traveled (had contact with resident populations) to a high-risk country for more than one week? Yes No

7.) Do you have a family member or contact with tuberculosis disease? Yes No

8.) Has a family member or contact had a positive tuberculin (TB) skin test? Yes No