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San Francisco, CA 94109
(415)668-0888 - ph.
(415)752-5391 - fax

61 Camino Alto, Suite 107
Mill Valley, CA 94941
(415)388-6303 - ph.
(415)388-7136 - fax

Golden Gate Pediatrics

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

Also, before submitting the form you need your doctor to complete to our office, please make sure all portions that need to be completed by you are complete as well.

Patient's Name: _____ **DOB:** _____

Primary Care Physician: _____

Method to return form: ***(select 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 ○