

TEACHER \_\_\_\_\_ GRADE \_\_\_\_\_  
STUDENT \_\_\_\_\_  
BIRTHDAY (MONTH, DAY, YEAR) \_\_\_\_\_

---

ADDRESS CITY STATE ZIP HOME PHONE

---

MOTHER'S NAME CELL PHONE WORK PHONE E-MAIL

---

FATHER'S NAME CELL PHONE WORK PHONE E-MAIL

CHECK ONE IF YES, EXPLAIN

YES NO

- \_\_\_\_\_ Any chronic or recurrent illness? \_\_\_\_\_
- \_\_\_\_\_ Presently taking any medication \_\_\_\_\_
- \_\_\_\_\_ Any problem with blood pressure or heart? \_\_\_\_\_
- \_\_\_\_\_ Any dizziness, fainting, seizures, or frequent headaches? \_\_\_\_\_
- \_\_\_\_\_ Wear eyeglasses, contact lenses or dental appliance? \_\_\_\_\_
- \_\_\_\_\_ Allergic to any medication? \_\_\_\_\_
- \_\_\_\_\_ Any knee or ankle injury? \_\_\_\_\_
- \_\_\_\_\_ Any knee surgery? \_\_\_\_\_
- \_\_\_\_\_ Any history of neck or head injuries? \_\_\_\_\_
- \_\_\_\_\_ Any broken bones? \_\_\_\_\_
- \_\_\_\_\_ Is student diabetic or hypoglycemic? \_\_\_\_\_
- \_\_\_\_\_ Any organ missing other than tonsils? \_\_\_\_\_
- \_\_\_\_\_ Any heat exhaustion or heat stroke? \_\_\_\_\_
- \_\_\_\_\_ Asthma – Where is medication kept at school? \_\_\_\_\_
- \_\_\_\_\_ Any reason why student should not participate in physical education? \_\_\_\_\_

Please send us a note if your child needs to miss a P.E. class. We will need a doctor's note if the student misses more than one week of P.E.

Thank you for your support.

Physical Education Department  
Dr. Lawton  
Mrs. Maxwell