# Student Health Record

To Be Completed By the Student and Parents/Guardians.

## Background Information

Student Name: _____ Date of Birth: _____

Address: _____

Parent or Guardian Name: _____

Home Phone Number: _____ Cell: _____

Work Phone Number: _____ Ext. _____

## Health Concerns

Please place a check mark on any of the following conditions that apply to you:

- □ Trouble breathing at rest
- □ Chest pain when exercising
- □ Diabetes
- □ Asthma
- □ Convulsions/fainting
- □ Pain in knees, ankles, or back
- □ High blood pressure
- □ Allergies, describe: _____

I wear a medical alert bracelet and it says:

_____

Other conditions, please explain:

_____

_____

## Overall Health

Please place a check mark beside whichever of the three statements below best describes you:

- □ I am in good health
- □ I am relatively healthy
- □ My health needs to be improved

Do You Like Health and Physical Education? _____

Previously, my physical education classes occurred _____ days/week. My health class occurred _____ a week.

What did you like most and least about your health and physical education class?

_____

_____