## **Student Health Record**

To Be Completed By the Student and Parents/Guardians.

Parent or Guardian Name:    Parent or Guardian Name:   Cell:	Background information	Date of Birth
Work Phone Number:	Student Name:	Date of Birth:
Home Phone Number:	Address:	
Work Phone Number:	Parent or Guardian Name:	
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:	Home Phone Number:	Cell:
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.	Work Phone Number:	Ext
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What did you like most and least about your health and physical education class?	Previously, my physical education classes occurred _	days/week. My health class occurred a week.