



# PHYSICAL EDUCATION PARTICIPATION FORM

Name of School \_\_\_\_\_ Name of Teacher \_\_\_\_\_

Class Period \_\_\_\_\_ Year \_\_\_\_\_

Dear Parent/Guardian,

The following information is needed by the Physical Education Department to permit us to be aware of the physical condition of your child in order to make necessary changes in his/her participation, if necessary.

## I. GENERAL INFORMATION (please print)

Name of Student \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of alternative person \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Parent Signature (Please sign) \_\_\_\_\_ Date \_\_\_\_\_

## II. PLEASE IDENTIFY MEDICAL CONDITIONS, MEDICATIONS AND/OR HISTORY WHICH YOU FEEL MEDICAL PERSONNEL NEED TO BE AWARE OF? (i.e. previous surgeries, chronic conditions, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## III. RESTRICTED PROGRAM (to be completed by a physician ONLY if there are restrictions)

Name of Student \_\_\_\_\_

Type of persistent health problem: \_\_\_\_\_

Should not participate in the following type at activities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Date: \_\_\_\_\_