

HEALTH STATEMENT

PLEASE RETURN THIS COMPLETE TO YOUR P. E. TEACHER

Name: _____ Class Period: **A B**
Advisory Teacher: _____ Grade: 9 10 11 12 Age: _____
Home Address: _____ Home Phone: _____
Work Phone: _____
Parent/Guardian: _____ Cell Phone: _____
Person to notify in emergency: _____ Phone: _____

Please list any physical conditions (such as allergies, bee stings, cut grass, asthma, seizures, need for medications, etc) that may limit your child's performance in the GTCHS physical education program.

Parents permission for participation and transportation in Physical Education:

I give my consent for my son/daughter to participate in all class activities and will inform the teacher **in writing** if any situation arises that will restrict activity. I also grant permission for the treatment deemed necessary for any condition that arises during activity, including medical treatment by a doctor. I understand that an effort will be made to contact me before such treatment. I certify that the medical history listed above is accurate to the best of my knowledge and that my child is covered by personal primary insurance.

Parent's/Guardian's Signature: _____ Date: _____

Greenville Tech Charter High School Physical Education