SPENCERPORT CENTRAL SCHOOL DISTRICT

71 Lyell Avenue
Spencerport, NY 14559

PHYSICAL EDUCATION FORM FOR NEW STUDENTS
(in district)

Student Name: _____

Grade: _____ **Phone #:** _____ **Date of Birth:** _____

Dear Parent/Guardian:

In order to provide our students with a safe and successful Physical Education experience, it is important that we are aware of any individual medical concerns. With this in mind, please complete the following and return to the nurse's office.

Does your child have, or has he/she ever had:

	NO	YES	If yes, please give details
Allergies			
Asthma (uses an inhaler)			
Seizures or convulsions			
Surgery			
Sustained a head injury (was unconscious)			
Take daily medication			
Heart Condition			
Nonfunctional or absence of eye, ear, kidney, testicle, ovary			
Wears eye glasses or contact lenses			
Uses a hearing aid			
Any medical condition not previously listed			

If no other physical limitations exist, please 'x' the following box: ☐

_____ _____ _____

Date **Signature of Parent/Guardian or Student over the age of 18** **Relationship**

Our Mission is to educate and inspire each student to love learning, pursue excellence and use knowledge, skills and attitudes to contribute respectfully and confidently to an ever-changing global community.