***VMMS Physical Education Health Survey:*** ***Please Print***

**Assigned Instructor’s Name:**

**Student (Name)** **Grade Level:**

**Parent/Guardian (Name)**

**(1)**  **Relation:**

**Home Phone:** **Cell Phone:**  **Work:**

**(2)** **Relation:**

**Home Phone:** **Cell Phone:** **Work:**

**E-Mail: 1) 2)**

|  |
| --- |
| ***\*Does your child have any physical limitations (asthma, etc.) or conditions (allergies, allergic reactions, etc.) that we need to be aware of that could interfere with participation in any physical education activities.******Please circle one:* *YES NO******If “YES”, please explain in detail below:*** |

***I HAVE READ (AND MY SIGNATURE VERIFIES) THAT I UNDERSTAND THE WRITTEN VMMS COURSE SYLLABUS, VMMS RULES AND PROCEDURES, AND VMMS HEALTH SURVEY PROVIDED BY THE VMMS PHYSICAL/HEALTH DEPARTMENT. PLEASE RETURN THE NEXT SCHEDULED CLASS DAY.***

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

(Student Signature) (Parent/Guardian Signature)