



Health Screening Form

Name: _____

What is the present state of your general health? _____

Physician's Name: _____

Person to contact in case of emergency: Name _____

Phone # _____

Are you presently taking any medication? _____

Are you now or have you been pregnant within the past 3 months? _____

Do you have now or have you had within the past year:

	YES	NO
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1. A history of heart problems?	_____	_____
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2. High blood pressure?	_____	_____
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3. A chronic illness?	_____	_____
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4. Advice from a physician not to exercise?	_____	_____
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5. Muscle, joint or back disorder that could be aggravated by this activity?	_____	_____
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6. Recent surgery (within the last 3 months)?	_____	_____
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7. Diabetes?	_____	_____
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8. Cigarette-smoking habit?	_____	_____
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9. High blood cholesterol?	_____	_____
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What regular physical activity to you presently do?

Where did you hear about the classes? Paper _____ Flyer _____ Friend _____ Other: _____

Privacy Statement

All information on this Health Screening Form is strictly confidential and for the sole purpose of teacher information.