Kyrene School District

Kyrene Athletic Programs

Student Name_____

Date of Birth_____ Sex_____ Grade_____ School_____

Height _____ Weight_____

Blood Pressure_____ Pulse_____

Eyes: R_____ L_____ Both _____

Physician's Report

Heart _____ Abdomen _____

Lungs_____ Throat_____

Spine _____ Hernia _____

Lower extremities _____ Upper extremities: _____

Physician Statement

I hereby certify that on this date I examined the above student and recommend her/him as being able to participate in all supervised athletics and physical education activities with no restrictions.

Physicians (MD/DO/NP/PA-C) Signature_____ Exam Date_____

Additional Comments: _____

_____

This physical covers all sports for one calendar year.