

Kyrene Athletic Programs

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Eyes: R \_\_\_\_\_ L \_\_\_\_\_ Both \_\_\_\_\_

### Physician's Report

Are there any issues with the following areas?

Heart: Y / N

Abdomen: Y / N

Lungs: Y / N

Throat: Y / N

Spine: Y / N

Hernia: Y / N

Lower extremities: Y / N    Upper extremities: Y / N

### Physician Statement

I hereby certify that on this date I examined the above student and they are:

- **Approved** to participate in all supervised athletics and intramural activities with no restrictions.

- **NOT** approved to participate in all supervised athletics and intramural activities.

Physicians (MD/DO/NP/PA-C) Signature \_\_\_\_\_ Exam Date \_\_\_\_\_

Additional Comments (if applicable) \_\_\_\_\_

**This physical covers all sports for one calendar year.**