DIOCESE OF PHOENIX ATHLETIC PHYSICAL FORM

To be completed and signed by a medical provider (M.D., D.O., N.P., PA-C)

_____ _____ _____ _____ _____

Last Name First Name Sex Grade Birth Date

Ht. _____ Wt. _____ Eyes: R20/_____ L20/ _____ With/without corrective lenses

Ears: L _____ R _____ Nose/Throat _____ Teeth/Dentures _____ Skin _____

Heart _____ Lungs _____ Blood Pressure (right arm sitting) _____

Abdomen _____ Hernia _____ Pulse Rest _____ 2min _____

Spine/Neck _____ Shoulders/Elbow/Hands _____

Hip/Knee _____ Ankle/Feet _____

Lymphatic _____

Laboratory: Urinalysis (dip stick) _____ albumin _____ sugar _____ blood _____

Other Lab tests (only if specifically indicated or required):

Urinalysis sp.gr _____ Hemoglobin/hct _____

Tuberculin test: Poss. _____ Neg. _____

Other: _____

I hereby certify that, on this date, I examined the above student and recommend him/her as being physically able to participate in all supervised athletics and physical education activities, except as noted:

Signature of Examining Medical Provider: _____

Name of Medical Provider (type/print) M.D./D.O./N.P./PA-C: _____