ST. JOHN'S COLLEGE HIGH SCHOOL
ATHLETIC TRAINING

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PHYSICIAN REFERRAL FORM

Name:

Sport:

Injury:

Date of injury:

Time of injury:

Location of injury:

To be completed by the physician. This form will be used by the Athletic Trainers of St. John's College High School as permission by the physician to treat the patient and will be filed in the student-athlete's medical records under strict confidential rule.

Physician's Diagnosis: _____

Physician's Recommendations:

Medication: _____

Tx/Rehab: Ice/Heat Cryocuff Cold / Warm Whirlpool Massage Jt Mobs

Therapeutic Exercise (ROM / Strength / Proprioception / Stationary Bike) Estim US

Is conditioning and/or strength training permitted with the sport team? Yes No

Physician Comments: _____

_____

Athlete's Sport Participation Status:

( ) May return to full participation without restrictions immediately
( ) May return to full participation without physician follow-up on the date indicated: _____
( ) When Cleared by the Athletic Trainer
( ) No sport participation until seen again by the physician

Next Visit: _____

_____
Physician Signature Date

_____
Print Physician name Telephone #

My signature below gives permission to the attending physician to release the medical information provided above to the Athletic Training staff of St. John's College High School for the purposes of treating my child for his/her injury.

_____
Parent/Guardian Signature Date