EANES ISD Sports Medicine: Physician Communication Form

Date: _____________
Athlete Name: _____________________
Provider Name/Signature: ____________________
Accepted Providers: MD, DO, PA, NP, DC

<u>Body Part Evaluated:</u>

<u>Detailed Injury Diagnosis:</u>

<u>Restrictions/Limitations (Sport Specific/Weight Room/Conditioning):</u>

<u>Follow Up / Release / Return to Athletic Participation Plan:</u>

Athlete may progress with the Athletic Trainer: Please circle one: Yes/No

<u>This information must be communicated & presented to the supervising Athletic Training Staff</u>

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Form Generated: April 2019