

Eanes ISD Sports Medicine Physician Communication Form

Date: _____

Athlete Name: _____

Provider Name / Signature: _____

Accepted Providers: MD, DO, PA, NP, DC

Body Part Evaluated:

Detailed Injury Diagnosis:

Restrictions / Limitations (Sport Specific / Weight Room / Conditioning):

Plan for Follow-up / Plan for Return to Athletic Participation:

Can the athlete progress with the athletic trainer? Yes / No (Please circle one)

This information should be communicated to the appropriate member of the athletic training staff

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