South Kitsap High School
Athletic Medicine Department
425 Mitchell Ave., Port Orchard, WA 98366
P: 360.874.5769 F: 360.874.5892

PHYSICIAN'S MEDICAL REFERRAL/REPORT

(This form must be returned before this athlete may return to participation in any sport activity)

Name: _____ Date: _____

Sport: _____ Level: _____ Position: _____

Grade: _____ School: _____

**** PARENT/GUARDIAN RELEASE FOR INFORMATION EXCHANGE****

I authorized release of the health care practitioner's exam findings and other pertinent medical data of this injury/illness as it relates to the participation of my child in South Kitsap High School Sports Activities. I understand that the documentation of this injury/illness will be kept on file in the SKHS Athletic Medicine Department. *"My signature indicates permission for the Physician and Athletic Trainer to exchange any and all information regarding this injury"*

Parent/Guardian Signature: _____ Date: _____

Date of Injury: _____

Injury:

Area/Cause:_____

_____

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Athletic Trainer: _____Date: _____

PHYSICIAN'S REPORT

Diagnosis:_____

_____

_____

_____

_____

Recommended Treatment:

_____

_____

_____

_____

_____

Return to Participation? [ ] Yes [ ] Full/Unrestricted
[ ] Modified at the discretion of the Athletic Trainer
[ ] Restricted

Explain:_____

_____

_____

[ ] No [ ] Reevaluation needed prior to return
(Date) _____
[ ] No Play Until
(Date) _____

Specialist Referral/Special Test? (Indicate Dr. and/or Test Ordered):

_____

_____

_____

** Modalities (Ice, heat, US, Stim, Laser, taping etc) are available with Physician Approval. **

MAY SCHOOL-BASED THERAPY (BY LICENSED STAFF) BE INITIATED?

[ ] YES [ ] NO

(If yes, please indicate any special treatment requirements and/or settings)

Notes/Instructions: _____

_____

_____

_____

_____

Doctor's Signature: _____ Date: _____

Doctor's Name (Print): _____ **Office Stamp Here**

Phone Number: _____