



Lyndhurst High School

400 Weart Ave Lyndhurst, NJ 07071

School Nurse: 201-896-2100 ext. 4025 - Fax: (201) 935-3511

Athletic Training Room: 201-896-2100 ext.4041

PHYSICIAN REFERRAL FORM

Dear Doctor,

Please fill out this form for the School Nurse/Athletic Trainer. I want to ensure the best care for our athletes while complying with your recommendations. Your help is greatly appreciated. Thank you.

Student Name: _____

Date of Injury: _____ Sport: _____

Description of Injury: _____

PLEASE COMPLETE THE FOLLOWING:

DIAGNOSIS: _____

RESTRICTIONS: _____

The above named athlete may return to Physical Education and Athletics:
____ Yes ____ No

The above named athlete is cleared for:
____ Full Activity ____ No Activity Until Re-evaluated

May return to participation on this date: _____

COMMENTS: _____

Physician's Name: _____ Physician's Signature: _____

Telephone Number

Physicians Stamp

Date

Please return with athlete or fax to: (201) 935-3511 (LHS School Nurse FAX)

***** This form MUST be completed and returned to the School Nurse or athletic Trainer BEFORE return to participation. *****