Monomoy Regional High School
Athletic Training
75 Oak Street
Harwich, MA
PHYSICIANS' REFERRAL FORM

Dear Medical Practitioner,
In order for us to give the best possible care to our athletes we want to follow the treatment plan you have designed for the following athlete. With the permission of the parent, please complete the following pertinent information. The MRHS Athletic Training Department **requires a hard copy release before an athlete can return to activity from the treating healthcare professional.** An athlete may not be able to participate without this form complete and on file with the school Athletic Trainer.
Name: ________________________ Date: _____________ Grade: ______ Sport/Activity:__________________
This student has been seen in the Training Room with:

--TO BE FILLED OUT BY THE PARENT-------------------------------------

I ___________________________ give ______________________________ permission to release medical
Parent/Guardian Name (print) Physician &/or Clinic Name
Information for __________________________ related to his/her ________________________
Athlete Name Injury/Illness
injury/illness to become a confidential permanent record of the Athletic Training Department at Monomoy Regional High School. _____________________________ _________
Parent/Guardian Signature Date

RECOMMENDED ACTIVITY	RECOMMENDED THERAPY (check all that apply)
_____ Complete Rest	_____ Flexibility/ROM _____ Contrast Bath
_____ Non-contact workout	_____ Bike _____ Thera-Tubing/Band
_____ Full contact WITH restrictions: ____________________________________	_____ Ice _____ Jog/Run
	_____ Agility Drills _____ Progressive Resistive
_____ Full contact NO restrictions	_____ Other
______ Released to Athletic Trainers	

Please provide the following information so this individual may be treated according to your instruction

Diagnosis:____

Any Special Instructions/Limitations:
____
____

Date of next appointment (if necessary):_____________________ Office Phone # :____________________

Printed name of physician/stamp:___________________________________ Fax # : __________________

Signature of physician: ______________________________________

Thank You,
Taylor Murray, ATC, LAT
Athletic Trainer
Office: Cell: 774-208-2563 tmurray@monomoy.edu

ATTENTION PARENT / STUDENT:

YOU MAY NOT *BE ALLOWED TO PARTICIPATE WITHOUT THIS FORM COMPLETE AND ON FILE WITH THE Monomoy Regional Athletic Department*