Freedom High School Sports Medicine
1050 Neroly Rd Oakley, CA 94561
Athletic Training Room • (925) 625-5900

Medical Referral

Date _____

Name _____ Sex: M F

School _____ Sport _____

Date of Injury [DOI]: _____ Phone # _____

Dear Parents or Guardian:

A Certified Athletic Trainer [ATC] has evaluated your athlete for an injury and/or symptoms which are effecting his/her athletic participation. Enclosed is a summary of the findings along with recommendations for self care and/or instructions for further evaluations by your primary care physician. This evaluation is NOT intended to replace the medical opinion given by the student's family physician. If you have any questions, please feel free to contact the Certified Athletic Trainer [ATC] at the below phone number.

Certified Athletic Trainer's Report

History _____

Impression _____

Self Care Instructions _____

_____ Physician Evaluation required prior to resuming athletic activities.

_____ If the symptoms get worse or do not improve significantly within 3-4 days, contact your physician.

Referred by: _____ Phone # _____

Physician's Report

Diagnosis _____

X-Ray Report [if taken] _____

Medication _____

Restrictions :

___ Full Go ___ Play to Tolerance ___ Non-Contact Activities ___ Limited Activities ___ Complete Rest

Comment on Restrictions _____

Exercise/Rehabilitation Recommendations _____

Recommended Date of Return: To Practice _____ To Play _____

Date of Return visit to physician if needed: _____

Physician Name _____

Physician's Signature Date

Address _____

Phone # _____

City,St Zip _____

Dear Physician:

We are requesting that you fill out this information so the certified athletic trainer may completely understand your recommendations and assist with the athlete's recovery. We are set up to do light rehab in the training room. Thank you.

WHITE	CANARY	PINK	GOLDEN ROD	
Return to Athletic Trainer	Physician's Copy	Parent's Copy	Training Room Copy	Aug 20, 1999 NCR-4