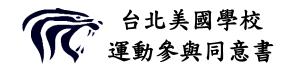
This form is to be completed & returned to the TAS Sports Medicine Team prior to participation after being medically excluded from activity due to injury or illness.

Patient's name	Current	activity	Date of Injury		
Reason for referral:					
☐ Caleb Lott MAT, ATC, NREMT	☐ TK Edwards MS,	ATC, CES	☐ Taylor Stevens MS, ATC		
> TO BE COMPLETED BY DOCTOR					
Diagnosis					
The recommended levels for physical activity					
□ NO RESTRICTION from further activity, discharging him/her/them and authorizing full participation.					
□ COMPLETE RESTRICTION for activity and sport for			(days/weeks/months).		
☐ LIMITED / MODIFIED RESISTRICTION. Student may return to participation with limited/modified restrictions.					
Please click on the following sports/activities that this student can participate in:					
O Upper body resistance exercises only	O Lower body resistance only		tationary biking		
O Jogging	O Elliptical	ON	WB Activities		
O Core stabilization exercises	O Aquatics	0 0	Others		
Please provide a description below on any therapy / restriction requests for TAS Sports Medicine Team					
		_			
Doctor's name / Signature:		Date of evaluation:			
Clinic / Hospital:		Telephone / Email:			
☐ Request to see patient at clinic/hospital on		for a follow-up consultation.			
> TO BE COMPLETED BY PARENT/GUARDIAN					

Once being medically cleared by the doctor above and / or TAS Sports Medicine Team, I give consent for my child to return to full participation in the above-named activity.

Parent / Guardian name (PLEASE PRINT)	Parent / Guardian name (SIGNATURE)

Date: YYYY / MM / DD



因運動傷害或身體不適而暫停體能活動後,在返回參與運動活動前,必須經由醫療診斷並填寫此表格,將此表填寫完畢交還給 TAS 運動醫學團隊。

299 A A A A					
學生姓名	目前從事的	運動項目	受傷日期		
轉診原因:					
Caleb Lott MAT, ATC, NREMT	TK Edwards MS, A	ATC, CES	Taylor Stevens MS, ATC		
▶ 請由醫師填寫					
診斷					
	體能活動限制程度建設	義			
□ 無限制, 該名學生可以參與任何體能活動。					
□ 完全限制(天/週/月)的活動和運動。					
□ 有限制 / 調整的,學生可以在有限制/調整下重新參與活動,請單擊該學生可以參加的以下運動/活動:					
○僅限於上半身的肌力訓練 C) 僅限於下半身的肌力約	東 ○室內	腳踏車		
○慢跑 C)滑步機	〇非承	重訓練		
○穩定核心肌群訓練 C	水上運動	〇 其他	活動		
請提供 TAS 運動醫學團隊關於該名學生所需的治療和體能活動限制內容					
醫師姓名/簽名:		診斷評估日期:			
診所/醫院名稱:		電話 /電子郵件:			
□ 該名學生需要回診的日期:					
▶ 請由家長 / 監護人填寫					
經上述醫生和/或 TAS 運動醫學團隊的醫學許可後,我同意我的孩子重新全面參與上述活動。					
家長 / 監護人 姓名 (正階) 家長 / 監護人 姓名 (簽名)					

Date: YYYY / MM / DD