CHISD Sports Medicine Injury/Illness Report

Name of Athlete:_____ **Date of Injury/Illness:** _____

Diagnosis of Injury/Illness:_____

Date of Follow up Appointment: _____

Recommended Activity:

( ) **Full Contact**

( ) **Non-Contact Vigorous**

( ) **Non-Contact Light**

( ) **Complete Rest**

May return to Full Contact in _____ days

- or -

After next examination set for _____

Other: _____

( ) **Evaluation, Treatment, and Return to Activity per Athletic Trainer**

Recommended Treatment:

( ) Hot Packs	( ) Hot Whirlpool	( ) Passive Exercises	( ) Ultrasound
( ) Cold Packs	( ) Cold Whirlpool	( ) Cold/Compression	( ) Active Exercises
( ) Contrast Packs	( ) Contrast Bath	( ) Resistive Exercises	( ) Other:
( ) Ice Massage	( ) Electrical Stimulation	( ) Home Exercises	

( ) **No Treatment at this time**

Frequency: ( ) once/wk ( ) twice/wk ( ) three/wk ( ) four/wk ( ) daily for _____ weeks

Comments: _____

_____

_____ _____

Physician Signature **Date** **Printed Name & Contact Information**

Or Physician's Stamp

Return to: Thomas Rhodes LAT, ATC • *469-272-2000 ext.8126*