

**ST. JOHN'S COLLEGE HIGH SCHOOL
ATHLETIC TRAINING**

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PHYSICIAN REFERRAL FORM

Name: _____
Sport: _____
Injury: _____
Date of injury: _____
Time of injury: _____
Location of injury: _____

Athletic Trainer's remarks: _____

To be completed by the physician. This form will be used by the Athletic Trainers of St. John's College High School as permission by the physician to treat the patient and will be filed in the student-athlete's medical records under strict confidential rule.

Physician's Diagnosis: _____

Physician's Recommendations:

Medication: _____

Tx/Rehab: Thermal Tx Thermal Compression Electric Stimulation US
Joint/Soft tissue Mobilization Therapeutic Exercise (ROM / Strength / Proprioception)

Is conditioning and/or strength training permitted with the sport team? Yes No

Physician Comments: _____

Athlete's Sport Participation Status:

- ☐ May return to full participation without restrictions immediately
- ☐ May return to full participation without physician follow-up on the date indicated: _____
- ☐ When cleared by the Athletic Trainer
- ☐ No sport participation until seen again by the physician

Next Visit: _____

Physician Signature

Date

Print Physician Name

Telephone number

My signature below gives permission to the attending physician to release the medical information provided above to the Athletic Training staff of St. John's College High School for the purposes of treating my child for his/her injury.

Parent/Guardian Signature

Date