



ATHLETE MEDICAL REFERRAL/CLEARANCE

ATHLETE

SCHOOL/SPORT

DATE

Dear Doctor: The athlete above must present to the school officials written permission to resume participation in both athletics and physical education. Please review this form and list diagnosis and any restrictions or specific instructions to be followed. Thank you for your help!

MECHANISM OF INJURY, SIGNS, SYMPTOMS AND IMMEDIATE CARE

GIVEN: _____

SUSPECTED INJURY/ILLNESS _____

EVALUATED BY: _____ **PARENT CONTACTED:** _____

FOR PHYSICIAN ONLY:

Doctor's diagnosis _____

TREATMENT	RESTRICTIONS	RETURN TO PLAY AFTER Athletic Trainer CLEARANCE _____
____ None	____ None	
____ Non-Weight bearing	____ Strengthening/rehab only	
____ PWB	____ R.O.M. Only	
____ Taping/Bracing	____ Non-Contact only	
____ ICE		
____ HEAT		

SPECIFIC INSTRUCTIONS/RESTRICTIONS _____

PE participation yes no _____

Formal Physical Therapy yes no _____

PHYSICIAN SIGNATURE/DATE _____

