Crater High School Sports Medicine

Physician Medical Referral/ Report Sam Drewes, MS, ATC

Cell: 218-368-9160

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Athletic trainers’ Impression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize release of the health care practitioners’ exam findings and other pertinent medical data of this injury/ illness as it relates to the participation of my child in Crater High School sports activities. I understand that the documentation of this injury/ illness will be kept on file in the Crater High School Sports Medicine Department.

Parent/ Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Recommended Treatment Protocol:

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_ Evaluate/ Treat as needed \_\_\_\_\_ Supportive Tape/Wrap/Brace\_\_\_\_\_ Hot/Cold Pack\_\_\_\_\_ Contrast Bath\_\_\_\_\_ Ultrasound\_\_\_\_\_ Electrical Stimulation | \_\_\_\_\_ AROM\_\_\_\_\_ PROM\_\_\_\_\_ Massage/ Effleurage\_\_\_\_\_ Stationary Bike\_\_\_\_\_ PNF Stretching\_\_\_\_\_ Joint Mobilization | \_\_\_\_\_ Active Release\_\_\_\_\_ LE Strengthening\_\_\_\_\_ UE Strengthening\_\_\_\_\_ Core Strengthening\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Instrument Assisted Soft Tissue Mobilization |

Frequency of Treatment: \_\_\_\_\_PRN \_\_\_\_\_ Daily \_\_\_\_\_ 3X \_\_\_\_\_ 2X \_\_\_\_\_1X per wk

Recommended Participation Level:

\_\_ Full- unrestricted \_\_ Limited Practice w/ Restrictions \_\_ NO Participation

Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Participation Status:

\_\_\_\_\_ Athlete may return to full activity after passing functional testing by certified athletic trainer.

\_\_\_\_\_ Athlete may return on approximately \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

\_\_\_\_\_ Athlete may return only after my next examination set for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Physician Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_