Sports Medicine Department

Physician Evaluation form

This form is to be completed by a physician and returned to the athletic training staff after evaluation.

Student-Athlete Name: _____

Date of evaluation: _____ **Sport**: _____

Physician Diagnosis: _____

Treatment Plan: The student-athlete may receive the following care from the athletic training staff in the Haverford School Athletic Training room:

[ ] Cold Therapy
[ ] Moist Heat Therapy
[ ] Electric Stimulation
[ ] Ultrasound
[ ] Resistance Exercise
[ ] Stretching / Range of Motion Exercise
[ ] Cardiovascular Exercise
[ ] Other: _____

[ ] Athletic Trainers may use any of these treatment modalities at their discretion.

_____

Return-to-Play: The student-athlete may return to play as follows:

[ ] The student-athlete may return to FULL activity immediately

[ ] The student-athlete may return to FULL activity on the following date: _____

[ ] The student-athlete may return to limited activity with these restrictions: _____

_____

[ ] The student-athlete may NOT return to activity until after his next office visit with me.

Physician Name *(or practice/facility stamp)*: _____

Address: _____ **Phone**: _____

Signature: _____

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