FLOWING WELLS HIGH SCHOOL
ATHLETIC INJURY MEDICAL REFERRAL

Student's Name _____ Sport _____

Referred to _____
(Physician's Name) (Address)

Phone Number_____ Appointment Date _____ Appointment Time_____

Referred by _____ Date of Referral _____

REASON FOR REFERRAL:

_ Original Injury _ Re-injury _ Other

Type of Injury _____ Date of Injury _____

Initial Assessment (signs & symptoms) _____

_____

PHYSICIAN'S REPORT:

Diagnosis _____

_____

X-ray Findings (if taken) _____

Recommendation for Activity:

_ Restricted until student - athlete's next appointment scheduled on _____

_ Full Participation (Note: school policy requires written medical release with physicians signature before full participation is allowed; please attach)

Comments

_____

_____

Further Recommendations (follow-up care, special padding, etc.) _____

_____

_____ _____
Name of Physician - printed or typed Signature of Physician

Date _____

1st copy: ATC 2nd copy: Physician