



## Vernon Township High School Athletic Training

### Physician Evaluation Form

**This form is to be completed by the physician and returned to the athletic training office**

Athlete's Name:

Date:

Sport:

Reason for Referral:

**Physician's Diagnosis:** \_\_\_\_\_

**Treatment:** The following treatments may be utilized in the rehabilitation of the above athlete.

Cold Therapy

Range of Motion Exercises

Cold Whirlpool

Resistive Exercises (bands, light weight)

Hydrocollator (moist heat packs)

Therapeutic Exercise

Electrical Stimulation

Cardiovascular Exercise (bike, elliptical)

Ultrasound

Please list any treatments/exercises to be avoided during the treatment process:

\_\_\_\_\_  
\_\_\_\_\_

Specific Instructions:

\_\_\_\_\_  
\_\_\_\_\_

#### Return to Activity and PE:

\_\_\_ The athlete may return to activity and PE on the following date: \_\_\_\_\_

\_\_\_ The athlete may return to activity and PE at the discretion of the athletic trainer

\_\_\_ The athlete may not return to activity and PE at this time

**Follow-up appointment date:** \_\_\_\_\_

\_\_\_ The athlete does not need a follow-up appointment

**Physician's Name/Address/Phone Number** (please print)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Comments:

---

---

---

---

---

---

---

---

---

---