

Goleman Senior High
GATOR ATHLETIC TRAINING

Injury Medical Referral Form

Date: ____/____/____

Athlete's Name (Last, First): _____, _____

Social Security #: ____ - ____ - ____ D/O/B: ____/____/____ Student Id. #: _____

Date of Injury: ____/____/____

Part of Body Injured: _____ Side(s) - _____

History of Injury: _____

Impressions: _____

Seth H. Fogler, MS Ed, LAT, Athletic Trainer

By submitting this form the patient and the parent/guardian agree that the Licensed Athletic Trainer (LAT) is part of the Health Care Team, and that the ATC is authorized to receive any and all medical information about the above mentioned student-athlete.

Medical Advisor's Report

Diagnosis: _____

X-Ray Report (if taken): _____

Medication Prescribed: _____

Treatment Recommendations: _____

While working with the Certified Athletic Trainer the following activity recommendations apply (check all that apply):

- Complete Rest
- Limited which may include (Exercises Non-Contact Drills Running Drills Other)
- Athlete may return to full activity on ____/____/____
 - while completing pre and post activity therapy
 - with no pre and post activity therapy
 - only after the next scheduled examination on: ____/____/____ at ____: ____ (am/pm)
 - as tolerated as long as no worsening of condition or increase in symptoms

_____/_____/_____
Physician's Name (Print) Physician's Signature Date

Physician's Phone Number: (____) _____ - _____