Physician Evaluation Form

Unionville Chadds-Ford School District Athletic Training

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TO BE COMPLETED BY ATHLETIC TRAINER

Date:_____

Dear Physician:

_____ (DOB:_____) has presented to the athletic training staff with the following injury due to his/her involvement in _____ here at Unionville High School.

Injured Body Part: _____ Athletic Trainers' Impression: _____

Comments:_____

TO BE COMPLETED BY PHYSICIAN

Diagnosis:_____

Comments: _____

Treatment Restrictions*:_____

Participation Status:

____ Must see physician before returning to participation
____ May return to participation at the discretion of the athletic trainer
____ May return to participation on the following date: _____.
____ Other (please specify): _____

Physician Name/Address/Phone Number (please print or stamp)

_____
_____
_____
_____

Physician Signature: _____ Date Signed: _____

*In accordance with the Pennsylvania Athletic Trainers' State Practice Act and Standing Orders Protocol, the athletic trainers will use at their discretion any combination of the following treatments provided they are indicated for the above condition (unless otherwise specified above by the treating physician): Cryotherapy, Thermotherapy, Ultrasound, Electrical Stimulation, Compression, Manual Therapy, Instrument Assisted Soft Tissue Mobilization, Therapeutic Exercise, Cardiovascular Exercise, Preventative/Prophylactic Taping/Bracing, and Home Exercise Programs/Educational Handouts to treat the above condition.