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SAVANNA HIGH SCHOOL PHYSICIAN MEDICAL REPORT

Student Athlete: _____

Date: _____

Sport: _____

DOI: _____

Physician's Name(Print): _____

Phone #: _____

Test(s) Performed: _____

Diagnosis: _____

Date Athlete May Return To Play -or- Date of Follow-Up Appt.: _____

Treatment Recommendations: _____

Modalities: ___ Whirlpool (Hot / Cold / Contrast)

___ Heat Pack

___ Massage

___ Cold Pack

___ Therapeutic Exercise

___ PROM/AROM/RRROM

___ STEM

___ Other - please describe

Signature: _____

Thank you for taking the time to complete this form. Our goal is to provide the best medical care for our student-athlete's by keeping an open line of communication with our physicians and carrying out your treatment and follow-up instructions. If you have any questions or concerns, feel free to call. Thank you.

*** Please return to your certified athletic trainer.**

