Physician Evaluation Form

Eastern High School
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This form is to be completed by the examining physician and returned to the athletic training office.

Date: _____

I have examined _____, who was injured while participating in

the following sport or activity: _____.

Physician Diagnosis: _____

Treatment: I recommend that the above student-athlete receive the following care by the certified athletic trainers at school (please check all that apply)

___ Whirlpool ( ) warm ( ) cold
___ Hydrocollator (moist heat packs)
___ Cold Therapy (ice pack, ice massage)
___ Electrical Muscle Stimulation
___ Therapeutic Ultrasound/Phonophoresis
___ Intermittent Compression
___ Electromyographic Feedback
___ Range of Motion Exercise
___ Resistive Exercise (bands, tubing, light weights)
___ Cardiovascular Exercise (bike, elliptical, running)
___ The athletic trainers may use any of these at their discretion

Return to Activity (please check one):
___ The athlete may return to activity on the following date: _____
___ The athlete may return to activity at the discretion of the athletic trainer.
___ The athlete is to see me again prior to resuming activities.

Physician's name and address (please print):

_____

_____

_____

Phone _____

Physician Signature _____

Please return this form to the Athletic Trainer's Office