# SKYLINE HIGH SCHOOL
# ATHLETIC TRAINING
# MEDICAL REFERRAL

Athlete:_____ Date of Referral: _____

Sport: _____ Date of Injury: _____

Impression of Injury:_____

Comments:_____

_____

*Please complete this form and have it returned to me/athlete to ensure that this athlete will receive the care that you have indicated. This will become a part of the student's medical record.

Thank you,

_____

Megan Swartz, LAT, ATC
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## PHYSICIAN'S REPORT

Diagnosis:_____

Rehabilitation Referral Indicated: Y or N

Clearance Status:
_____ Athlete may return to participation on _____.
_____Athlete may not return to participation until further notice.
_____ Athlete may return to participation at the discretion of the Athletic Trainer.
_____Athlete may return to participation with the following restrictions/limitations:

_____

_____

Comments: _____

_____

_____

Physician's Name: _____

Physicians Signature: _____