CB South Physician's Report

CB South Athletic Training

Athlete Information

Athlete Name:	Sport:
Sport:	Body Part:
Clinical Impression of Injury:	
Comments:	

Please complete this form to ensure that the student athlete receives the proper medical care you have prescribed. **This will become a part of the athlete's permanent medical record and may be returned via the student athlete or faxed to the athletic office, attention Kelley Peloquin at 267-893-3190.** If you have any questions, please feel free to contact me at 267-221-5053 or kpeloquin@cbsd.org. Thank you for your assistance.

Respectfully,

Kelley Peloquin, MS, ATC
Certified Athletic Trainer, PRO Physical Therapy

Diagnosis: _____

Clearance Status

- ☐ Referral to specialist: _____
- ☐ Cleared for full participation
- ☐ Cleared to return with the following restrictions:
  _____
  _____
- ☐ Cleared to return with the following protective device: Brace Tape Other
  Please note any specifications: _____
  _____
- ☐ May not return until: _____
- ☐ May return after passing functional testing by the Certified Athletic Trainer

Rehabilitation Reccomendations

Rehabilitation Referral Indicated: Yes No (Please send with a prescription)
Rehabilitation Location: PRO Athletic Training Room Other:
If rehab referred to ATR:

Preferred exercises: _____
_____

Limitations: _____
_____

Modalities: Hot Pack Electric Stim Ultrasound Whirlpool

Additional Comments

_____
_____
_____

Physician's Name: _____

Physician's Signature: _____ Date: _____