

JC Bermudez - Doral Senior High School
Thunder Athletic Training

5005 N.W. 112 Avenue
Doral, FL 33178
305-715-3600 Ext ****

Injury Medical Referral Form

Date: ___/___/___ Sport: _____

Athlete's Name (Last, First): _____, _____

Student Id. #: _____ D/O/B: ___/___/___

Doctor: _____ Appointment Date: ___/___/___ Time: ___ : ___

Date of Injury: ___/___/___

Part of Body Injured: _____ Side(s) - _____

History of Injury: _____

Impressions: _____

Certified/Licensed Athletic Trainer

By submitting this form, the patient and the parent/guardian agree that the Licensed Athletic Trainer (LAT) is part of the Health Care Team, and that the LAT is authorized to receive all medical information about the above-mentioned student-athlete.

Parent/ Guardian Signature acknowledge the above statement.

Medical Advisor's Report

Diagnosis: _____

X-Ray Report (if taken): _____

Medication Prescribed: _____

Treatment Recommendations: _____

While working with the Certified Athletic Trainer the following activity recommendations apply (check all that apply):

- Complete Rest
- Limited which may include (Exercises Non-Contact Drills Running Drills Other)
- Athlete may return to full activity on ___/___/___
 - while completing pre and post activity therapy.
 - with no pre and post activity therapy.
 - only after the next scheduled examination on: ___/___/___ at ___: ___ (am/pm)
 - as tolerated as long as no worsening of condition or increase in symptoms.

Physician's Name (Print) Physician's Signature _____ / ___ / ___
Date

Physician's Phone Number: (____) _____ - _____