**WENATCHEE HIGH SCHOOL**
**PHYSICIAN'S MEDICAL REFERRAL/REPORT**

Date_____ Name_____

Sport_____ Level_____ Position_____

Athletic Trainer's Impression_____

_____

Certified Athletic Trainer_____

I authorize release of the health care practitioner's exam findings and other pertinent medical data of this injury/illness as it relates to the participation of my child in Wenatchee High School sports activities. I understand that the documentation of this injury/illness will be kept on file in the WHS Sports Medicine Department.

Parent/Guardian Signature_____Date_____
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***PHYSICIAN'S REPORT***

**Diagnosis**_____

_____

Recommended Treatment_____

_____

***RECOMMENDED PRACTICE LEVEL:***

_____Full, unrestricted practice _____No practice

_____Limited practice with the following restrictions:_____

***RETURN TO ACTIVITIES:***

_____Athlete may return to full activity after passing functional testing by certified athletic trainer.

_____Athlete may return on approximately _____ (date).

_____Athlete may return only after my next examination set for_____.

***FURTHER RECOMMENDATIONS:***_____

_____

*Physicians' signature*_____ *Date*_____