



Athlete Information (parent to complete):

Athlete Name: _____ Age: _____ Parent Name: _____

Injury Information (DR/PA to complete):

Physician Name: _____ Contact #: _____

Date Athlete Seen: _____

General Description of Injury:

Has athlete been referred to physical therapy or other on-going treatments (circle one): YES / NO

Ability to Practice/Limitations:

_____ Do not return to activity at any level at this time.

_____ Limited Duty, with any limitations noted below

_____ Full activity as tolerated, with any limitations noted below

_____ Other: _____

_____ Cleared for full participation in all activities without restriction.

If any other status than cleared for full participation:

- Anticipated number of weeks the athlete will be at current status: _____

- At the end of this anticipated number of weeks (choose one):

_____ Athlete is cleared for full participation in all activities without restriction

_____ Athlete must return to receive follow up and/or release from medical professional

_____ Other: _____

For Limited Duty, Full Activity with restrictions, or "other" status:

Please list specific limitations or instructions as of today as it relates to practice and physical activity. Please be as specific as possible regarding any exertion, jumping, stretching, impact, or risk of falling activities:

Physician Signature

Date Signed