Westwood High School Sports Medicine
Physician Clearance

Patient Full Name: _____ Date of Birth: ___/___/____

Athletic Trainer Section

Body Part Injured: _____ Referred by: _____
Sport: _____
MOI: _____
Exam findings:_____
Please rule out: _____
Appointment Date: ___/___/____ Time: ___/___/____ Location: _____

Parent Section

As parent/guardian of the above named patient, I give permission to the Physicians and/or staff of _____ to release medical information to Athletic Trainers at Westwood High School.

_____ _____ _____
Parent/Guardian Printed Name Parent/Guardian Signature Date

Physician Section

Diagnosis: _____
Treatment/Rehab indications: _____
_____

Recommendations/Restrictions:

□ Return to Full Practice and Competition.
□ Return to Full Practice and Competition if able to complete running program.
□ Return to Full Practice and Competition if able to complete throwing program.
□ Return to Full Practice and Competition after completing rehab program with Athletic Trainer.
□ Non-contact drills only.
□ Conditioning drills only.
□ Progress to full activity as symptoms subside.
□ No activities until further notice.
□ Wear padded cast or splint for _____ weeks, starting ____/____/_____
□ Tape or splint for practice and competition.
□ Other: _____

Follow-up

□ PRN □ Imaging Studies: _____
□ Next office appointment date: ____/____/_____

Physician Stamp or Office Contact Information:

Physician Signature: _____ Date: _____