Commerce High School Athletic Training
Student-Athlete Health Care Provider Visit Form

The Commerce High School Athletic Training staff would like you to complete this form so our office has documentation of the athletes visit as well as any related recommendation you have for his/her rehabilitation and other care. We thank you in advance for getting this to our office as quickly as possible.

Date of visit: _____________ **Name**: ___________________________ **Sport**: ________________

Physician Name: _________________________________Physician Phone#:__________________
Physician Address: ____
Physician Email: _________________________________ Physician Fax#: ____________________

1. **Diagnosis:** ____
   ____

2. **Prescribed treatment and rehabilitation protocol:**________________________________
   ____
   ____
   ____
   ____
   ____

3. **Is the athlete released to full-contact athletic activity? YES NO**
   Restrictions/modifications: ____
   ____
   ____
   ____
   ____

4. **Follow-Up YES NO: When:** ____

Physician Signature: ____ **Date**: ______________

Please return Form to:

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