

**TOWNSHIP H.S. DISTRICT 211
HOFFMAN ESTATES HIGH SCHOOL
ATHLETE MEDICAL REFERRAL**

| | | |
|---------|-------|------|
| ATHLETE | CLASS | DATE |
|---------|-------|------|

SPORT _____

Dear Doctor: The athlete above must present to the school officials written permission from the physician to resume participation in both athletics and physical education classes. Thank you.

SIGNS, SYMPTOMS AND IMMEDIATE CARE GIVEN:

ROGER A. KALISIAK, ATC/L
 DONNA T. WISELY, ATC/L
 (847) 755-5790

SUSPECTED INJURY / ILLNESS _____

OCCASION: _____ Game _____ Practice _____ PE _____ Other: _____ Parent Contacted: _____ Yes _____ No _____

(From) _____ (To) _____

SPECIFIC DIAGNOSIS

PERIOD OF RESTRICTIONS

Physical Education (Check One)

(Check all that are applicable)

TREATMENT

REHABILITATION

- | | |
|---|---|
| <p>_____ None Required</p> <p>_____ No Weight Bearing</p> <p>_____ Crutches</p> <p>_____ Ice Packs</p> <p>_____ Cold Whirlpool</p> <p>_____ Warm Whirlpool</p> <p>_____ Ice Massage</p> <p>_____ Hydrocollator Hot Pack</p> <p>_____ Massage</p> <p>_____ Contrast Baths</p> <p>_____ Protective Taping</p> <p>_____ Protective Padding</p> <p>_____ Ultrasound</p> <p>_____ EMS</p> <p>_____ No Contact</p> <p>_____ Limited Contact</p> <p>_____ Running/Jogging Only</p> <p>_____ Dummy Drills Only</p> <p>_____ Full Contact</p> <p>_____ Other: _____</p> | <p>_____ None required</p> <p>_____ Active Stretching</p> <p>_____ Passive Stretching</p> <p>_____ R.O.M. Exercises</p> <p>_____ Isometrics</p> <p>_____ Manual Resistance</p> <p>_____ Progressive Resis.</p> <p>_____ Isotonic/Isokinetic</p> <p>_____ Orthotron Program</p> <p>_____ Bicycle</p> <p>_____ Swimming</p> <p>_____ Slideboard</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|---|---|

Regular _____

Regular – Minor Restrictions _____

SPECIFIC INSTRUCTIONS FOR ATHLETICS

Frequency _____ x per day for _____ weeks

Physician's Name Printed

Physician's Signature

Date

Phone No.