Conroe Independent School District
Physician Referral for Athletics
("Doctor's Note")

Name:_____ **Date:**_____ **Grade:**_____ **Sport/Activity:**_____

The above-named student has been seen in the Training Room with:

_____

Please provide the following information so this individual may be treated according to your instructions.

Diagnosis:_____

RECOMMENDED ACTIVITY	RECOMMENDED THERAPY (check all that apply)	
_____Complete Rest _____ Weeks_____Days	_____ Cold Whirlpool	_____ Flexibility/ROM
_____Non-contact workout–Light _____Weeks_____Days	_____ Warm Whirlpool	_____ Bike
_____Non-contact workout–Vigorous_____Weeks_____Days	_____ Contrast	_____ Jog/Run
_____ Full contact WITH restrictions:_____	_____ Ice	_____ Agility Drills
_____	_____ Moist Heat	_____ Lower Body Workout
_____	_____ Ultrasound	_____ Upper Body Workout
_____	_____ Muscle Stimulation	_____ Tape/Brace
_____ Full contact NO restrictions	_____ Progressive Resistive Exercise	
_____ Treat as needed	_____ Other:_____	

Any Special Instructions/Limitations:_____

_____

Date of next appointment (if necessary):_____ **Office Phone #:**_____

Printed name of physician:_____

Office Stamp:

Signature of physician:_____

Please return this form with the student, by fax, or by mail.

Thank You - _____

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ATTENTION STUDENT:

YOU WILL NOT BE ALLOWED TO PARTICIPATE WITHOUT THIS FORM COMPLETE AND ON FILE WITH THE SPORTS MEDICINE DEPARTMENT