FRANCIS PARKER SCHOOL
Athletics
Fax (858) 569-0942

6501 Linda Vista Road
San Diego, CA 92111
Phone (858) 569-7900

MEDICAL / INJURY FORM

Athlete:______________________________________ Age:______ Male/Female Date: ____________

Sport:____________________ Position:________________ Injury Description: ______________________

Occasion: ___Game____Practice____Other:___________ Parent Contacted:_________________________

SIGNS, SYMPTOMS, AND IMMEDIATE CARE GIVEN:

____
Athletic Trainer/Coach Signature

Specific Instructions to Athlete: ____

Has appointment been made? Yes____No____ If yes, Physician__________________Date_____________

MEDICAL REPORT (Completed by Physician)

Diagnosis:
Treatment Recommended:

PHYSICAL THERAPY (specify)

____ time(s) per ____week(s)
Rx:______________________
____

TO BE RECHECKED:

____ Days
If not better in _____ days
____ will not need to return

ACTIVITY RECOMMENDED (check)

______ Full Activity
______ Limited Activity
(Restrictions)_______________
____
____
______ No Activity/Other
(Identify)__________________
____
____

MAY RETURN TO FULL ACTIVITY (check)

____ Today
____ Days
____ After next exam

COMMENTS:____

Physician's Name Printed   Physician's Signature   Title   Date   Phone No.

(Completed by Parent)

I give my consent for ____________________________________ to follow these recommendations in retuning to Francis Parker Athletics.

Parent/Guardian Name Printed   Parent/Guardian Signature   Date   Phone No.