Hawaii State Department of Education

MEDICAL REFERRAL FORM FOR ATHLETES

PART I (To be filled out by Athletic Health Care Trainer or Athletic department staff)

Name _____ Grade _____ Age _____ Date _____

Date of Injury _____ Area Injured _____ Sport _____ Level: ❑ Varsity ❑ JV

Mechanism of Injury _____

_____

Assessment of Injury _____

Treatment rendered _____

Notification of Parent/Legal Guardian: By whom _____
(Athletic Trainer or Athletic Department Staff)

How was parent/legal guardian notified _____ Time _____ Date _____
(Phone, Written or Verbally)

Referred to: ❑ Emergency Room ❑ Family Physician ❑ Other Physician

Referred by _____ _____ Date _____
(Name) (Position)

PART II (To be filled out by Parent/Legal Guardian)

RELEASE OF MEDICAL INFORMATION AND PARENTAL CONSENT TO TREAT

The above named student and parent(s)/legal guardian(s) hereby consent to the release of medical information by

_____ to _____ high school to obtain information regarding
(Physician's Name) (Name of School)

the medical history, records of the above injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of the student's injury/illness. This information is confidential and except as provided in this release will NOT be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/legal guardian in writing. The student and parent/

legal guardian further consent and authorize _____ High School's Athletic Health Care Trainer(s) to
(Name of School)

provide appropriate therapeutic modalities in order to return the student to athletic competition, such care to be conducted under the direction of the student's physician.

Parent/Legal Guardian's Signature _____ Date _____

PART III (To be filled out by Physician)

Physician's Name _____ Phone No. _____

Address _____ Fax No. _____

Diagnosis _____

Prognosis _____

❑ Athlete able to Return to FULL ACTIVITY _____
(Comments)

❑ Athlete able to Return to RESTRICTED ACTIVITY _____
(Comments)

❑ Athlete UNABLE to Return to ACTIVITY UNTIL _____
(Comments)

❑ RE-EXAMINE Date _____

TREATMENT PRESCRIBED

❑ Evaluate and Treat	❑ Rest (days)_____	❑ Ice	❑ Hot Pack
❑ Electrical Stimulation	❑ MENS	❑ Whirlpool	❑ Ultrasound
❑ Range of Motion	❑ Resistive Exercises	❑ Massage/MFR	❑ Tape/Splint

Recommendation _____

_____

_____

_____ _____
(Physician's Signature) (Date)

RETURN THIS FORM TO YOUR SCHOOL'S ATHLETIC HEALTH CARE TRAINER OR ATHLETIC DIRECTOR

Rev. 5/13, RS 13-1284 (Rev. of RS 06-1384)