



Round Rock High School

Athletic Training

300 N. Lake Creek Drive

Round Rock, Texas 78681

Fax: (512) 464-6119



PHYSICIANS' REFERRAL FORM

Dear Medical Practitioner,

In order for us to give the best possible care to our athletes we want to follow the treatment plan you have designed for the following athlete. With the permission of the parent, please complete the following pertinent information. The RRHS Athletic Training Department **requires a hard copy release before an athlete can return to activity from the treating healthcare professional.** An athlete may not be able to participate without this form complete and on file with the school Athletic Trainer.

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

This student has been seen in the Training Room with: _____

-----TO BE FILLED OUT BY THE PARENT-----

I _____ give _____ permission to release medical
Parent/Guardian Name (print) Physician &/or Clinic Name
Information for _____ related to his/her _____
Athlete Name Injury/Illness
injury/illness to become a confidential permanent record of the Athletic Training Department at
Round Rock High School. _____
Parent/Guardian Signature Date

RECOMMENDED ACTIVITY	RECOMMENDED THERAPY (check all that apply)	
<input type="checkbox"/> Complete Rest	<input type="checkbox"/> Cold Whirlpool	<input type="checkbox"/> Flexibility/ROM
<input type="checkbox"/> Non-contact workout	<input type="checkbox"/> Hot Whirlpool	<input type="checkbox"/> Bike
<input type="checkbox"/> Full contact WITH restrictions: _____	<input type="checkbox"/> Contrast Bath	<input type="checkbox"/> Thera-Tubing/Band
_____	<input type="checkbox"/> Ice	<input type="checkbox"/> Jog/Run
<input type="checkbox"/> Full contact NO restrictions	<input type="checkbox"/> Moist Heat	<input type="checkbox"/> Agility Drills
<input type="checkbox"/> Released to Athletic Trainers	<input type="checkbox"/> Muscle Stimulation	<input type="checkbox"/> Progressive Resistive
	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Other

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

Diagnosis: _____

Any Special Instructions/Limitations: _____

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

Printed name of physician/stamp: _____ Fax #: _____

Signature of physician: _____

Thank You,

Nikki Vincent, ATC, LAT

Athletic Trainer

Office: 512-464-6127

Cell: 512-771-0790

José Carrillo, ATC, LAT

Athletic Trainer

Office: 512-464-6122

Cell: 512-619-0237

ATTENTION PARENT / STUDENT:

YOU MAY NOT BE ALLOWED TO PARTICIPATE WITHOUT THIS FORM COMPLETE AND ON FILE WITH THE ROUND ROCK ATHLETIC TRAINING DEPARTMENT