ROLLING MEADOWS HIGH SCHOOL
ATHLETIC TRAINING

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HOSPITAL OR PHYSICIAN______________________ TODAY'S DATE__________INJURY DATE__________

STUDENT'S NAME____________________ ID#_______AREA INJURED______________________

ATHLETIC TRAINER'S COMMENTS____

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PHYSICIAN'S DIAGNOSIS____

PHYSICIAN'S COMMENTS____

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THE FOLLOWING TREATMENT(S) SHOULD BE PERFORMED AT ROLLING MEADOWS HIGH SCHOOL, UNDER THE SUPERVISION OF THE ATHLETIC TRAINING STAFF, AS DESCRIBED HEREIN:

( ) ICE, COMPRESSION, ELEVATION
( ) HYDROCOLLATOR HEAT PACKS
( ) ICE MASSAGE
( ) WHIRLPOOL ( ) COLD ( ) HOT ( ) CONTRAST
( ) ULTRASOUND
(*Intelect Legend XT Unit)*
( ) ELECTRICAL MUSCLE STIMULATION
(*Intelect Legend XT Unit*)
( ) STATIONARY BICYCLE
( ) RECUMBENT STATIONARY BICYCLE
( ) UPPER BODY ERGOMETER
( ) ELLIPTICAL
( ) STAIRMASTER
( ) TREADMILL, 0-15 MPH, 0-15 DEGREE INCLINE
( ) WALKING/JOGGING/RUNNING
( ) WEIGHT TRAINING MACHINES
( ) FREE WEIGHT TRAINING
( ) STRETCHING
( ) FUNCTIONAL TRAINING EXERCISES
( ) R.O.M. EXERCISES
( ) SWISS BALL PROGRAMS
( ) BOSU BALL ACTIVITIES
( ) BAPS (ANKLE PLATFORM SYSTEM)
( ) LATERAL MOVEMENT SLIDE BOARD

( ) FOAM ROLLER ACTIVITIES
( ) BALANCE ACTIVITIES
( ) LUMBAR STABILIZATION ACTIVITIES
( ) MEDICINE BALL ACTIVITIES
( ) THERABAND EXERCISES
( ) FUNCTIONAL FLEXIBILITY
( ) PROGRESSIVE RESISTANCE EXERCISES
( ) ADDITIONAL REHAB. RECOMMENDATION
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( ) PROTECTIVE BRACING
( ) PROTECTIVE PADDING
( ) PROTECTIVE TAPING
( ) WOUND CARE
( ) CUSTOM MOLDED PLASTIC PROTECTIVE PAD
( ) GAME/ACTIVITIES <u>CAN</u> PARTICIPATE IN__________
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( ) GAME/ACTIVITIES <u>CAN NOT</u> PARTICIPATE IN________
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CRITERIA FOR RETURN TO PHYSICAL EDUCATION, PRACTICE, AND GAME

( ) Must see physician before returning to P.E. / Practice / Game.

( ) Limited P.E. Class / Practice / Game with the following restrictions :______________________

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( ) May return to P. E. / Practice / Game without physician recheck upon: ability to perform normal pain-free range of motion, have strength within normal limits and complete functional and sport specific tests.

PHYSICIAN'S CONTACT INFORMATION________________________________

PHYSICIAN'S SIGNATURE_____________________________DATE__________

*****PLEASE RETURN THIS FORM, COMPLETED AND SIGNED, TO THE STUDENT – THANK YOU*****