



Barrington High School Sports Medicine

“Home of the Broncos and the Fillies”

616 W. Main St. Barrington, IL 60010

Phone: 847-842-3263 Fax: 847-842-3401



Today's Date: _____ Date of Injury: _____

Name: _____ Sport: _____

Initial Impression: _____

Initial Findings: _____

To Be Completed By Physician

Dx: _____ Physician Findings/Comments: _____

Permission for athletic trainers to evaluate and treat as needed.

Formal physical therapy required for this injury _____ Visits

_____ Visits/week X _____ Weeks

Return to Practice/Game Criteria

Must see physician before returning to participation.

May return to participation without physician recheck upon:

- Ability to perform normal pain-free ROM and strength tests.
- Ability to pass functional progression tests determined by the athletic trainers.

May return to participation immediately.

May return to participation on this date: _____

Physician Name (please print)/Phone number

Physician Signature/Date

* If formal physical therapy is required, physician signature may constitute required prescription for treatment

**This form must be completed and returned to the athletic trainers
BEFORE return to sports**