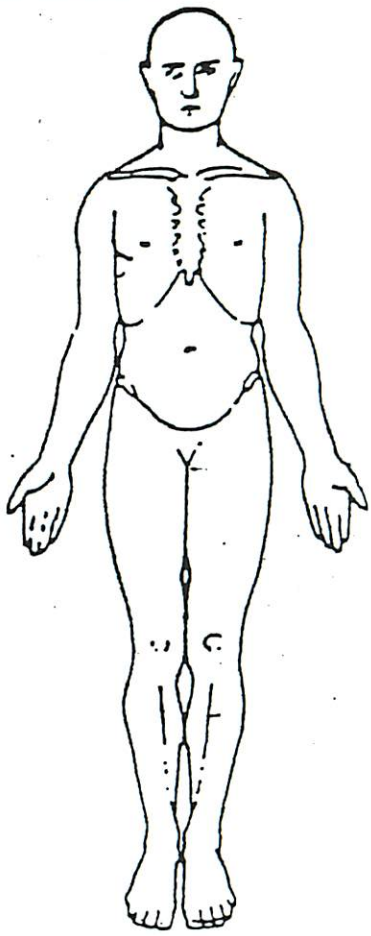
Insurance_____

GILROY HIGH SCHOOL ATHLETIC INJURY REPORT

NAME: _____ SPORT: _____
GRADE: _____ DATE OF INJURY: _____
PARENT NAMES: _____ TIME: _____
HOME PHONE: _____ DATE COMPLETED: _____
ALT. PHONE: _____ COMPLETED BY: _____



SUBJECTIVE: (Mechanism of Injury) (Previous Injury) Yes_____ No_____

_____

_____

_____

OBJECTIVE TESTS:

_____ 1. Observations: _____
_____ 2. Functional Tests: _____
_____ 3. Palpation: _____
_____ 4. AROM: _____
_____ 5. PROM: _____
_____ 6. Isometric: _____
_____ 7. Muscle Test: _____
_____ 8. Stability/ Special Tests: _____
_____ 9. Other: (neurological, vascular, girth) _____

_____

_____

_____

ASSESSMENT:

_____

_____

_____

First Aid Treatment: _____

_____

TREATMENT PLAN: _____

_____

_____

M.D. Referral_____ Kaiser_____

Athletic Trainer_____

Doctor's Diagnosis: _____

_____

Doctor's Recommendation: _____

_____

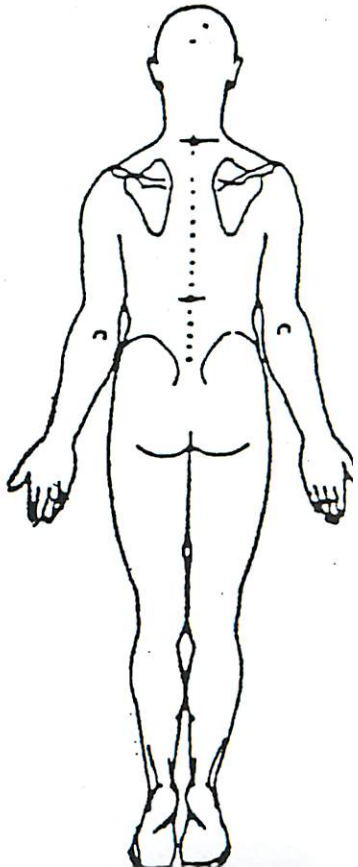
(Can this athlete practice, and if so, under what limitations?)
Modifications to practice _____

_____

_____Cleared for practice/competition

_____ _____

Doctor's Signature Date



If there are any questions or comments regarding the follow-up on this athlete, please contact: Jennifer Spinetti-Lightfoot ATC, Gilroy High School. V.M. (408) 847-2424 ext. 8645 or Cell # (831) 524-0501.