

**MEDICAL ADVISOR'S REPORT**  
**Messiah College Athletic Training Department**

Sandy Bush, ATC Head ATC 717- 691-6037  
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Athlete Directions: This form must be completed by the attending physician or medical specialist. One copy must be returned to the Athletic Training Staff (with the athlete's signature) before the athlete can be returned to participation.

Athlete's Name \_\_\_\_\_ Date of Visit \_\_\_\_\_  
Nature of the Athlete's injury/illness (per ATC) \_\_\_\_\_  
ATC requesting referral \_\_\_\_\_ Phone # \_\_\_\_\_

**MD Evaluation** (to be completed by physician only: MD, DO, podiatrist, dentist, etc. Others see below.):

\_\_\_\_\_

**Diagnostic Tests with results:** \_\_\_\_\_

\_\_\_\_\_

**Recommended Rx/Procedures:** \_\_\_\_\_

\_\_\_\_\_

**Recommended Activity:**

\_\_\_\_\_ Full Contact/Practice \_\_\_\_\_ Remedial Exercise/No Practice\*\*  
\_\_\_\_\_ Non Contact/Vigorous Practice\*\* \_\_\_\_\_ Complete Rest/No Practice  
\_\_\_\_\_ Non Contact/Light Practice\*\* \_\_\_\_\_ Other: See below\*\*

\*\*Describe/specify limitations \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Athlete may return to participation in approximately \_\_\_\_\_ days or after follow up exam tentatively scheduled for \_\_\_\_\_ at \_\_\_\_\_ am / pm.

Physician's Name (print) \_\_\_\_\_ Phone # \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Nurse concerns/recommendations** (to be completed by nurse/other specialist, CRNP, etc.)

\_\_\_\_\_

Plan for follow-up/Physician referral \_\_\_\_\_

Nurse Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Nurse Signature \_\_\_\_\_

I hereby authorize the release of the above information including diagnostic test results, diagnoses, etc. to the Messiah College Athletic Training Department. I understand that any information provided is confidential.

Athlete's Signature \_\_\_\_\_ Date \_\_\_\_\_