



Elkins Physical Therapy Service
 1520 Harrison Avenue
 Elkins, West Virginia, 26241
 www.elkinsphysicaltherapy.com

STUDENT ATHLETE INJURY SCREEN

Name: _____ DOB: _____ Date: _____
 Phone: _____ Email: _____
 Parent/Guardian Name: _____ Contact Number: _____
 Sport: _____ Position: _____ Coach: _____

By my signature below, I the responsible guardian of the athlete above, authorize physical therapy consultation and exam as needed. Goals of the screen include evaluation, assessment of the sport injury, recommendations for best ongoing management of the injury. I authorize release of the information related to this screen and ongoing health information of the athlete to the named parent(s)/guardian(s), coach listed above.

Parent/ Gaurdian Signature: _____ **Date:** _____

If necessary I authorize the release of this health information to the following medical office(s) and/ or providers: _____

Parent/ Gaurdian Signature: _____ **Date:** _____

Description of Injury/ Nature of Symptoms:

Screening Exam Findings: _____

Assessment: _____

Recommended Management Plan:

Rest and Ice. Avoid painful activity.

Practice and Sport Participation Recommendation: _____

Rehab Training/ Exercise/ Activity Prescription: _____

Formal Clinic Based PT Needed

MD Evaluation Needed

Physical Therapist Signature: _____

Date: _____