

Return to Sport Form for Injury/Illness

Desert Mountain High School Sports Medicine

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***This form is to be completed when an athlete is seen by ANY healthcare provider outside of school (does not include DMHS school nurse or athletic trainer)**

Date: _____

This is to certify _____
(Athlete's Name/DOB)

Was seen in my office on _____
(Date)

Diagnosis: _____

Activity Level Allowed: _____

Other information regarding injury: _____

Follow-Up Appointment Date: _____

(Dr. Signature)

(Dr. Phone Number)