USATF 2017 INDOOR

Sports Medicine

Athlete Log

Name: _____ Date: _____

DOB:	SEX:	Event:	
Allergies:		Medications:	
Body Part:		Side:	Pain Level: 0 1 2 3 4 5 6 7 8 9 10
Chief Complaint:			

Medical Professional:

- ☐ Doctor
- ☐ Nurse
- ☐ Athletic Trainer
- ☐ Massage Therapist
- ☐ Chiropractor
- ☐ Other_____

Treatment Plan 1:

_____

_____

_____

_____

Medical Professional Name: Credential: Signature:

Treatment Plan 2:

_____

_____

_____

_____

Medical Professional Name: Credential: Signature:

Treatment Plan 3:

_____

_____

_____

_____

Medical Professional Name: Credential: Signature:

Medications/Other Interventions:

_____

_____

Medical Professional Name: Credential: Signature

Athlete **Signature:**_____ **Date:**_____