



Dear Doctor,

Re: _____ (DOB ____/____/____)

The above-named member of Australind Swimming Club has advised their Coach that they are seeing you for treatment of an injury or illness. This member is involved in a performance training squad, to participate in normal training they are required to complete:

- High impact, repetitive movements (pushing off walls, turns, diving, underwater kick etc)
- Increased heart rate (aiming for “red zone” frequently during sets), and
- Pool training sessions of 1.5-2 hrs duration, _____ times per week
- (If applicable – Strength and Conditioning gym sessions 2 times per week)

Can you please assist us in ensuring the safety of the member during their recovery from illness or injury by completing the below questions to clarify reasonable expectations?

1. Has the illness/injury full stabilised? YES / NO
2. Can this swimmer return to full competition training, without limitations? YES / NO
 If NO, when is it likely the swimmer can return to full training? _____
3. Can the swimmer commence a modified program (if available)? YES / NO
 What is the anticipated duration of the need for a modified program? _____

| MODIFICATIONS (if relevant) | | | |
|------------------------------------|--|-----------------------|----------------------------------|
| Heart Rate | 170+ | Yes | No |
| | 140 – 170 | Yes | No |
| | Below 140 only | Yes | No |
| <i>Comments (if limited):</i> | | | |
| Upper Limb | Range of Movement | Full | Limited |
| | Weight Bearing | Full | Limited |
| <i>Comments (if limited):</i> | | | |
| Lower Limb | Range of Movement | Full | Limited |
| | Weight Bearing | Full | Limited |
| <i>Comments (if limited):</i> | | | |
| Back/Spine | Range of Movement | Full | Limited |
| <i>Comments (if limited):</i> | | | |
| Pain | What is an acceptable amount of pain for the swimmer to continue to train? | | |
| | Nil – stop if any pain | Small amount / niggle | Expect some pain, stop if severe |
| <i>Comments:</i> | | | |



| Stroke Specific Information | | |
|-----------------------------|-----------|-----------|
| Stroke | Movement | OK to do? |
| Freestyle | Full | YES / No |
| | Kick only | YES / No |
| | Arms only | YES / No |
| Backstroke | Full | YES / No |
| | Kick only | YES / No |
| | Arms only | YES / No |
| Breaststroke | Full | YES / No |
| | Arms only | YES / No |
| | Kick only | YES / No |
| Butterfly | Full | YES / No |
| | Kick only | YES / No |
| | Arms only | YES / No |

Doctors Comments:

Doctor Name: _____

Date: _____

Signature: _____

Provider Number: _____

We thank you for taking the time to provide this information and supporting our swimmers return to full health and strength.

Kind Regards,

Caitlin Crispin
Senior Coach
Development Coach
Australind Swimming Club

Consent (parent to complete if under 16yrs):

By providing this completed form to Australind Swimming Club, I understand the information contained may be shared with the clubs coaching team to enable planning for a safe return to training. I acknowledge that a modified program may not be available, depending on coach and pool resources available.

Name: _____

Signature: _____

Date: _____