## **Sports Medicine Request for Services**

Lisa Geiger, MS, ATC, CSCS Asst. AD of Sports Medicine 0 (518) 454-2009 C (516) 315-0534 Georgia Knight, ATC Assistant Athletic Trainer 0 (518) 454-2009 C (802)793-9949 Megan Wilburg, ATC Assistant Athletic Trainer O (518) 454-2009 C (802)282-8198

The athletic training room is open two hours prior to the start of all games, and closes 30 minutes following the conclusion of any contest. The following is a list of items/services that will be available to you; water and cups, ice and ice bags, crutches, splints & AED (home bench only).

Available
modalities: Electric
stimulation
Ultrasound
Crutches
Moist heat packs
Whirlpool (main campus only)

If your team is **traveling without an athletic trainer**, notify a member of the Saint Rose staff at least 24 hours prior to travel. A letter from your athletic trainer must accompany the athlete, plus all necessary supplies. **Please fill out the questionnaire listed below**, and return it to the Saint Rose athletic training staff.

## Sports Medicine Medical Questionnaire

Please complete the following and forward to a member of the College of Saint Rose Sports Medicine Staff. All information is completely confidential and is strictly used to assist the sports medicine staff in preparing for your arrival and participation at Saint Rose, E-mail: geigerl@strose.edu

| Name of   |  |
|---|--|
| Institution: Head   |  |
| Coach:  |  |
| Certified Athletic Trainer:   |  |
| • Will you be traveling with the team?                                      |  |
| • Do you want the host athletic trainer to attend to your injured athletes? |  |

In the event that a Certified Athletic Trainer is not traveling with the team, please list the athletes' name and treatment guidelines that they will need below.

| Name           | Treatment |
|----------------|-----------|
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|                |           |
|                |           |
|                |           |
| Ohl or Company |           |

| Other Concerns: _ |  |  |  |
|-------------------|--|--|--|
|                   |  |  |  |
|                   |  |  |  |
|                   |  |  |  |

## **Sports Medicine Request for Services**

| Name of ATC:      | Date: |  |
|-------------------|-------|--|
| Signature of ATC: | Date: |  |
| Email:            | Fax:  |  |

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