Prescription/Screening Results

Rx

Athlete's Name: _____ **Date:** _____

Measured Foot Size: *Left:* _____ *Right::* _____

OUSA OEuro OEng OAsia

Recommended Shoe/Sock type: *Shoe* _____ *Sock* _____

☐ **Congratulations**, you have **FIT FEET** and require no follow-up care

Healthy Athletes Fit Feet

☐ **You have the following condition(s):**

- ☐ over pronation
- ☐ bunion
- ☐ hammer toe
- ☐ corns
- ☐ calluses
- ☐ other _____
- ☐ warts
- ☐ arthritis
- ☐ athlete's feet
- ☐ nail fungus
- ☐ high arches

Treatment for these conditions are listed below.

_____

_____

_____

_____

☐ **Your feet require extended treatment; please contact the following physician for a follow-up appointment:**

_____

_____

_____

_____

_____

Prescribing Physician Signature

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