1455 Madison Avenue, Redwood City, CA 94061-1549   650) 368-7732

Dear Dr.________________________

Your patient, ________________________, desires to enroll in an Adaptive Physical Education class offered at the Veterans Memorial Senior Center in Redwood City. Based on your input, the student will have an individually designed fitness program with their needs, interests, and abilities in mind. This program is not a substitute for physical therapy; rather, we offer an educational program for medically stable persons with a focus on lifelong fitness. Our program emphasizes cardiovascular conditioning, muscular strength, flexibility, balance and fall prevention, and social interaction. For effective and safe programming, we prefer to have a Physician's Approval form completed prior to their participation. Please fill out the electronic form on our website and email it to us or mail us a paper copy.

Thank you for your input--we appreciate your taking the time to complete this. We look forward to having your patient participate in our Program!

If you have any questions or comments about our program, please call us at (650) 368- 7732 or visit us at our website: www.adaptivepevmsc.org

Sincerely,

Barbara McCarthy, M.A., Registered Kinesiotherapist

Scott Lohmann, M.A., Fitness and Aging Specialist

CONSENT FOR RELEASE OF INFORMATION:

PATIENT SIGNATURE_________________________ DATE__________

Adaptive Physical Education is a non-profit 501(c)(3) charitable organization **Non-Profit I.D. #: 46-3037547**

PHYSICIAN'S APPROVAL FOR ADAPTIVE PHYSICAL EDUCATION

NAME____________________________________ DATE OF BIRTH__________________

DIAGNOSIS AND HEALTH STATUS: _______________________________

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PLEASE LIST SPECIFIC FUNCTIONAL LIMITATIONS (i.e. walking, balance, vision, speech, self care)

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ARE THERE ANY OTHER MEDICAL PROBLEMS, PRECAUTIONS OR SITUATIONS THAT WE SHOULD BE AWARE OF (safety, communication, cognitive status, motivation, etc.)?

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WHICH ACTIVITIES WOULD BE MOST BENEFICIAL FOR YOUR PATIENT? WHAT WOULD YOU LIKE TO SEE THIS PERSON ACCOMPLISH?

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PHYSICIAN INFORMATION

NAME____

ADDRESS-- CITY, STATE, ZIP____

OFFICE PHONE_________________________ **EMAIL**_______________________________

DATE__________________________________

PHYSICIAN'S SIGNATURE ____