VETERANS MEMORIAL SENIOR CENTER

ADAPTIVE PHYSICAL EDUCATION

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: _____

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

_____

_____

_____

PHYSICIAN INFORMATION

NAME_____

ADDRESS-- CITY, STATE, ZIP_____

OFFICE PHONE_____ EMAIL_____

DATE_____

PHYSICIAN'S SIGNATURE _____